MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

87d

11535

Reg. Dist. No. 4/14

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
9014 Georgia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9014 Georgia Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
ARTHUR NOEL O. ARMSTRONG

3.(b) Social Security Number
579-05-6492

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Dorothy Painter

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1888

8. AGE: Years	Months	Days	If less than one day
59	10	18	____ hrs. ____ min.

9. Birthplace: Northern Ireland
(Town, county, and state)

10. Usual occupation: Former Manager La Frentz Co.

11. Industry or business: Certified Public Accountants

FATHER
12. Name: James Armstrong
13. Birthplace: Ireland

MOTHER
14. Maiden name: Anna C. Fichborne
15. Birthplace: Ireland

16. Informant: Mrs. Caroline Cain

Address: 9014 Georgia Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1948 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Baltimore, Md.

18. Funeral director: Warner E. Pumphrey, Inc.

Address: 8434 Georgia Ave., Silver Spring, Md.

19. Nov. 15 1948 Josephine M. Schaefer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 13 1948 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. med. Exam Case 19____ to 19____ and that I last saw h____ alive on 19____

Immediate cause of death

	DURATION
Multiple Sclerosis	11 yrs
Due to	
Due to	
Other conditions	

(Is Maryland attending physician)
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Brochert M.D.
Dep. med. Examr
M. D. or other

Address: Gaithersburg Md Date signed: 11-18-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

130

11536

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1009½ St. King St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI ✓

3. (a) FULL NAME
ATWELL, John Burieguard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6, 1893

8. AGE: Years	Months	Days	If less than one day
55	4	13	hrs. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: ~~XXXM~~ ATWELL, John B. dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: SCHUMAN, Kate dec.
15. Birthplace: Va.

16. Informant: sister: Mrs. Anne Barrett
Address: 1009½ St. King St., Alexandria, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-22-48 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Alexandira, Va.

18. Funeral director: Cunningham Funeral Home W.B.M.

Address: Alexandria, Va.

19. 11-19- (Date rec'd by registrar) 19 48 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 19 48 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 November 19 48 to 19 November 19 48 and that I last saw him alive on 19 November 19 48

	DURATION
Immediate cause of death: Edema, Lungs	2-4 hrs.
Due to: Nephritis, Acute	3 days
Due to: Hepatitis, Acute	6 days
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. A. DINSMORE, Jr., LCDR MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-19-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11537

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 months

Hospital, Institution, or street address where death occurred: 45 Poplar Avenue

How long in hospital or institution? 20 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1301 Longfellow St. NW

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME CLARA ERIE AUFRECHT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Carl Aufrecht

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 13, 1871

8. AGE: Years 77 | Months 8 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: Benjamin Tartell

13. Birthplace: Germany

MOTHER

14. Maiden name: Katherine

15. Birthplace: Germany

16. Informant: Mr. Carl G. Aufrecht

Address: 7722 Emerson Rd. West Lanham, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26 1948 (month) (day) (year)

Cemetery or crematory: Prospect Hill Cemetery

Location: N. Capitol & W. Sts. Washington, D.C.

18. Funeral director: J. Arthur Walters

Address: 254 Carroll St. NW Takoma Park, D.C.

19. Nov 24 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 1948 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1946 to Nov. 23 1948 and that I last saw her alive on November 16 1948

Immediate cause of death	DURATION
Coronary occlusion	1 hr.
Due to: Coronary Sclerosis	10 yrs.
Due to: Essential hypertension	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel M. Bayard M.D. M. D. or other

Address: 5600 N.H. Ave. Wash. D.C. Date signed: 11/23/48

11538

164C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (Rural) Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred: U S Naval Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt 1 Box 219
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II Army

3.(a) FULL NAME
BATSON, Richard Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 25 November, 1906

8. AGE: Years 42 | Months 0 | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Richard Batson
13. Birthplace: Maryland Deceased

MOTHER
14. Maiden name: Rose Hawkins
15. Birthplace: Maryland Deceased

16. Informant: Sister: Ellen Cook
Address: Rt 1 Box 219 Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-30-48 (month) (day) (year)
Cemetery or crematory: St Luke Churchyard
Location: Meadows, Maryland

18. Funeral director: W. Ernest Jarvis L.H.
Address: 1432 "U" Street NW Washington DC

19. 11-28 1948 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 November 1948, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. Case 19 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Toxemia	
Due to: gas gangrene	
Due to: Gun shot wound in rt Thigh	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: homicide Date of: 11-21-48
Where did injury occur? Forestville (City or town) Prince (County) Md (State)
Injured at home, farm, industry, public place (where?): Brown station Rd
Means of injury: shot gun Injured at work? no

23. SIGNATURE: Frank J. Bronhart M.D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md Date signed: 11-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131

11539

Reg. Dist. No. ~~216~~ 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2000 Conn. Avenue, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWII

3. (a) FULL NAME BENSON, Clarance Raywood

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Elizabeth Benson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1, 1903

8. AGE: Years	Months	Days	If less than one day
45	6	29	hrs. min.

9. Birthplace: Okla.
(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Federal Power Co.

FATHER
12. Name: BENSON, George
13. Birthplace: Neb.

MOTHER
14. Maiden name: PUCKETT, Etta
15. Birthplace: Mo.

16. Informant: wife: Mrs. Elizabeth Benson
Address: 2000 Conn. Avenue, Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-1-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: Georgetown, D.C.

19. 11-30 (Date rec'd by registrar) 19 48 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 19 48, at 6:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 November 19 48, to 30 November 19 48 and that I last saw h im alive on 30 November 19 48

Immediate cause of death	DURATION
Nephritis, Chronic	5 Mo
Due to: Hypertension, arterial	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Queen
W. F. QUEEN, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11540

82

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: 11-Hills Are Takoma Park - Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Mo's.

Hospital, institution, or street address where death occurred: Garrard Nursing Home

How long in hospital or institution? 4 Mo's

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 708 - 18 - St N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Dorothea Mary Bolten.

3. (b) Social Security Number:

4. Sex: F.

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 27-1888

8. AGE: Years: 60 | Months: 9 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Des Moine Iowa
(Town, county and state)

10. Usual occupation: Government Clerk - Int. Rev.

11. Industry or business:

MOTHER FATHER

12. Name: John Bolten.

13. Birthplace: Holland

MOTHER

14. Maiden name: Elizabeth Kopp.

15. Birthplace: Holland

16. Informant: Mrs. Louis J. Bolten.

Address: Old Georgetown Rd - Rockville R.F.D. 5

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov - 8 - 1948 (month) (day) (year)

Cemetery or crematory:

Location: Des Moine Iowa.

18. Funeral director: J. Arthur Walters

Address: 254 - Carroll St. Takoma Park.

19. Nov. 4 1948 (Date rec'd by registrar) J. Wm. Doff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1948 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to Nov. 4 1948 and that I last saw her alive on July 1948

Immediate cause of death: Angiotrophic lateral sclerosis

Due to: —

Due to: Unknown

Other conditions: Arteriosclerosis with hypertension
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eugene Brigulio M.D. M. D. or other

Address: 2025 Eye St NW Date signed: 4 Nov. 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11541

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Weeks

Hospital, Institution, or street address where death occurred:
401 Rosemary St., CH.Ch., Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 Rosemary St.,
(If rural, give LOCATION)

2.(a) If veteran name war: No

3. (a) FULL NAME
JULIA ANN BOUTIN

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel Boutin

6.(c) If alive, give age: Dec years

7. Birth date of deceased (mo., day, yr.): January 27, 1856

8. AGE: Years	Months	Days	If less than one day hrs.	min.
92	9	24		

9. Birthplace: Norwich, Ontario, Canada
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: William Crawford
13. Birthplace: Ireland

MOTHER
14. Maiden name: Elizabeth Piper
15. Birthplace: Canada

16. Informant: Mrs. Claude R. Porter
Address: 3752 Kanawha, N.W., Wash, D.C.

17. Burial-Transit Date thereof: Nov. 24, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: City Cemetery

Location: Cape Girardeau, Missouri

18. Funeral director: Wm. Rawlins Humphrey
Address: Bethesda, Maryland

19. 11-23 1948 W.E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1948 at 11:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 1948 to November 21 1948 and that I last saw her alive on November 20 1948

Immediate cause of death: Bronchopneumonia — DURATION: 4 days

Due to:

Due to:

Other conditions: Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert T. Darnall M.D.
M.D. or other

Address: 5516 Wis. Ave. — D.C. Date signed 11/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
NOV 26 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11542

93d

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 days
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.
How long in hospital or institution? 46 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME
Mrs. Mary S. Brady

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widowed.
6.(b) Name of husband or wife: Owen C Brady
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 18, 1866
8. AGE: Years 82 | Months 7 | Days 14 | If less than one day ..... hrs. ..... min.
9. Birthplace: Camp Springs, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: John Day
13. Birthplace: Maryland.
MOTHER 14. Maiden name: Mary Darsey
15. Birthplace: Maryland.
18. Informant: Hospital records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 5, 1948 (month) (day) (year)
Cemetery or crematory: Camp Springs
Location: Camp Springs P.O. Md
18. Funeral director: Robert J. Mattingly
Address: 1311-12 St. & E. Ward D.C.
19. 11-2- 1948 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2, 1948, at 1:15 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 20 1948, to November 2 1948
and that I last saw her alive on November 2 1948
Immediate cause of death: Inanition — DURATION 3 mo
Due to: Arteriosclerosis generalized — years
Due to: Arteriosclerotic heart disease — years
Other conditions: Osteoarthritis — years
(Include pregnancy within 3 months of death)
Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: C. N. Bryan M.D.
M. D. or other
Address: Sandy Spring Md Date signed: 11/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11543

94a

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montg

City or town: Glen Echo (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ day

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2945 - 29th St N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Leon Brill

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Martha Brill

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Jan 1892

8. AGE:

Years	Months	Days	If less than one day
56	10	10	hrs. min.

9. Birthplace: New York City
(Town, county, and state)

10. Usual occupation: Teacher trainer

11. Industry or business

FATHER
12. Name: Leon Brill
13. Birthplace: Russia

MOTHER
14. Maiden name: Esther Helfgott
15. Birthplace: Russia

16. Informant: Dr Warren Brill

Address: 1221 Mass Ave N.W. - DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov-30-48 (month) (day) (year)

Cemetery or crematory: Bnai Israel Cem

Location: Glen Hill Md

18. Funeral director: B Daumansky & Son

Address: 3501 - 14th St N.W.

19. Nov 28 1948 Josephine Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 1948, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1948, to 1948 and that I last saw h alive on 1948

Immediate cause of death: Coronary occlusion

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: died suddenly

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchart M.D. Dep Med Exam
M. D. or other

Address: Gaithersburg Md Date signed 11-28-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d 11544

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: 4923 Cordell Ave Bethesda Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Inetitution, or street addrese where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda MD.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lansing E Broadhurst

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of hueband or wife: Ester L. Broadhurst

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 1 - 1891

8. AGE: Years 57 Months 4 Days 23 If less than one day hrs. min.

9. Birthplace: Montgomery Co MD (Town, county, and state)

10. Usual occupation: None

11. Industry or business: Non

FATHER 12. Name: William H Broadhurst

13. Birthplace: Montgomery Co MD

MOTHER 14. Maiden name: Allie B Beall

15. Birthplace: Montgomery Co MD.

16. Informant: Mrs. Ester L. Broadhurst

Addreee: 4923. Cordell Ave Bethesda

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 28-1948 (month) (day) (year)

Cemetery or crematory: Bethesda Md

Location: Brookville, MD.

18. Funeral director: Roy W Barber

Addrese: Laytonsville Md

19. Nov 24 1948 (Date rec'd by registrar) W E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1948 at 12:15 PM

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from Dep med Exam 19 to case 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute cardiac dilatation	1/2 hr.
Due to: Chronic Valvular heart	1 yr.
Due to: disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death wae due to external causes, fill in the following:

Accident, euicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Induetry, public place (where?)

Meane of injury Injured at work?

23. SIGNATURE: Frank J Broschart M.D. Dep med Exam M. D. or other

Address: Gaithersburg Md Date signed 11-23-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11545

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Years

Hospital, Institution, or street address where death occurred:
101 N. Adams St., Rockville, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 N Adams St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
William Trew Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Elizabeth England Brown

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): August 8, 1864

8. AGE: Years: 84 Months: 2 Days: 23 If less than one day: hrs. min.

9. Birthplace: Chestertown, Kent Co., Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Cornelius Comegytus Brown
13. Birthplace: Chestertown, Maryland

MOTHER
14. Maiden name: Elizabeth Trew
15. Birthplace: Chestertown, Maryland

16. Informant: Lillian England Brown-Daughter

Address: 101 N Adams St., Rockville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Nov. 3/48 (month) (day) (year)

Cemetery ~~or crematory~~: Chestertown, Md. Cemetery

Location: Chestertown, Maryland

18. Funeral director: Wm. Reuben Plumphrey

Address: 7557 Wisconsin Ave., Bethesda, Md

19. 11-2 1948 (Date rec'd by registrar) E R Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1948 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1 1948 to 11/1 1948 and that I last saw him alive on November 1 1948

Immediate cause of death: Carcinoma of prostate — Duration: 1 1/2 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Willis Welch M.D. M. D. or other

Address: Rockville Md Date signed: 11/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11540

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long is above place of death? 16 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long is hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: [illegible]

City or town: Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME

BRUYN, Jasper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Agnes M. Bruyn

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 15, 1891

8. AGE:

Years	Months	Days	If less than one day
57	3	19	hrs. min.

9. Birthplace: Holland (Town, county, and state)

10. Usual occupation: Joiner

11. Industry or business

FATHER

12. Name: BRUYN, Jan dec.

13. Birthplace: Holland

MOTHER

14. Maiden name: VAN VLIET, Suzanna Maria dec.

15. Birthplace: Holland

16. Informant: wife: Mrs. Agnes M. Bruyn

Address: Edgewater, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-8-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 11-4- 1948 Mary C. Patterson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1948 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 October 1948 to 4 Nov. 1948 and that I last saw him alive on 4 November 1948

	DURATION
Immediate cause of death: Pneumonia	
Bronchopneumonia	5 days
Due to: Post operative -	
Due to:	
Other conditions: Carcinomatosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Sigmoid with metastasis Date of op. 10-29-48

Autopsy results: none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. N. Hanner J. N. HANNER, Cdr. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-4-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

11547

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
809 Houston Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 809 Houston Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MISS ANNA GRACE BURKE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 8-28-1865

8. AGE: Years 83 | Months 3 | Days 2 | If less than one day hrs. min.

9. Birthplace: Covington, Kentucky
(Town, county, and state)

10. Usual occupation: Gov't Employee - Retired

11. Industry or business: U.S. Government

FATHER
12. Name: James J. Burke
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Sullivan
15. Birthplace: New York

16. Informant: (Mrs) Geraldine C. Duncan

Address: 809 Houston Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-2-48 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Bladensburg Rd NE Washington, D.C.

18. Funeral director: J.T. Nixon Co.

Address: 2901-14-St. N.W. Washington, D.C.

19. Nov 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10 1940 to Nov 29 1948 and that I last saw her alive on Nov. 29 1948

Immediate cause of death: Congestive Heart Failure — DURATION 18 days

Due to: Hypertension — 8 yrs.

Due to: Arteriosclerosis — 8 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Jas. H. Goodall M.D.
M. D. or other

Address: 1746 - K St. N.W. Date signed: 11/30/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11548

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. Apt. 56, 2520 14th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME BURROWES, Alfred Dimick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 2, 1890

8. AGE: Years	Months	Days	If less than one day
58	9	4	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: Civil Service

11. Industry or business: Maritime Commission

FATHER
12. Name: BURROWES, Henry dec.
13. Birthplace: Pa.

MOTHER
14. Maiden name: DIMICK, Mary dec.
15. Birthplace: Pa.

16. Informant: son: Mr. Thomas H. Burrowes

Address: Harvard University, Cambridge, Mass.

17. Cremation
(Burial, cremation, or removal. Which?)
Date thereof: 11-8-48
(month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: 4000 Suitland Rd, Suitland, Md.

18. Funeral director: W. W. Chambers F.C.

Address: 1400 Chapin St NW, Washington, DC

19. 11-6-48 M
(Date rec'd by registrar)
Mary C. Patterson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 November 19 48, at 10:48 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 October 19 48, to 6 Nov. 19 48 and that I last saw him alive on 6 November 19 48

	DURATION
Immediate cause of death: Cerebral thrombosis	10 days
Due to: Arteriosclerosis generalized	Indef.
Due to:	
Other conditions: Myocardial fibrosis	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. F. Berry
J. F. BERRY
Lt. JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-6-48

16116

11549

83a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 33 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415 E. Leland St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clarence D. Butchart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bertha
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 11, 1878.

8. AGE: Years	Months	Days	If less than one day hrs.	min.
70	8	19		

9. Birthplace: Grand Rapids, Mich. (Town, county, and state)
10. Usual occupation: Cardiographic engineer
11. Industry or business
FATHER 12. Name: Joseph Butchart
13. Birthplace: Gulph - Canada
MOTHER 14. Maiden name: Martha Seering
15. Birthplace: Canada
16. Informant: Bertha L. Butchart (wife)
Address: Same
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec. 2, 1948 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Washington, D.C.
18. Funeral director: Wm Reuben Pumphrey
Address: Bethesda, Maryland.
19. 12-1 1948 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30, 1948 at 9 05 P. M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Nov 28 1948 to Nov 30 1948 and that I last saw him alive on Nov 30 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E. E. Quayle M.D. M. D. or other
Address: 1822 Biltmore St. N.W. Wash. D.C. Date signed 12/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

132

11550

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. #4 Congress Court, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME
BUTLER, George Richard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col-US	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 16, 1894

8. AGE: Years	Months	Days	If less than one day
54	6	1	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER
12. Name: BUTLER, John R. dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: GENTRY, Molly dec.
15. Birthplace: N.C.

16. Informant: sister: Miss Ruth Butler
Address: #4 Congress Court N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-22-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. ERNEST JARVIS 22 H

Address: 1432 U St., N. W., Washington, D.C.

19. 11-18 (Date rec'd by registrar) 1948 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 November 1948, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 November 1948 to 17 November 1948 and that I last saw him alive on 17 November 1948

	DURATION
Immediate cause of death: Pulmonary Edema	24 hrs
Due to: Acute left heart failure	24 hrs
Due to: Chronic Uremia & hypertension	1 yr
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: S. R. Mills Jr.
S. R. MILLS, Jr., Lt. JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-18-48

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11551

170C

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sudden
Hospital, Institution, or street address where death occurred: Md Route 28
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg RFD #3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME Robert H. Chapman Jr

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: X
6.(c) If alive, give age: X years
7. Birth date of deceased (mo., day, yr.): December 5th 1942

8. AGE: Years: 5 Months: 11 Days: 13 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual occupation: Student-St Martins Catholic Church
11. Industry or business
FATHER 12. Name: Robert H. Chapman, Sr.
13. Birthplace: Ft. Wayne, Ind.
MOTHER 14. Maiden name: Mabel Reall
15. Birthplace: Poolesville, Md.
16. Informant: Father- Same address
Address: RFD #3 Gaithersburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 20/48 (month) (day) (year)
Cemetery or crematory: Monocacy
Location: Beallsville, Md.
18. Funeral director: Wm. Rankin Pumphrey
Address: 7557 Wis. Ave., Bethesda, Md.
19. 11-20 1948 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18 1948 at 5:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def. med. Exam Case 19 to 19
and that I last saw h alive on 19
Immediate cause of death: Compound fracture of Skull (accidental)
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
DURATION: Killed instantly
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 11-18-48
Where did injury occur? Mr. Rockville (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): Highway
Means of injury: struck by auto Injured at work? No
23. SIGNATURE: Frank J. Brosnahan M.D. Def. Med. Examiner M. D. or other
Address: Gaithersburg Md Date signed: 11-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of given name, birth date, age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11552

94a

FILM No. G 118 NOV 18 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
1908 Glen Ross Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: "cedarhurst", Shady Side, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur ~~ALBERT~~ BERTRAM CLAXTON, JR.

3.(b) Social Security Number 577-10-7321

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Hannah Butler Claxton

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. ~~12~~ 14, 1899

8. AGE: Years	Months	Days	If less than one day
49	0	~~19~~ 18	hrs. min.

9. Birthplace: District of Columbia
(Town, county, and state)

10. Usual occupation: Manager Cannon Ball Truck Co.

11. Industry or business

FATHER
12. Name: Arthur B. Claxton, Sr.
13. Birthplace: D. C.

MOTHER
14. Maiden name: Lovie L. Thomas
15. Birthplace: D. C.

16. Informant: Mrs. Hannah Butler Claxton

Address: "Cedarhurst", Shady Side, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 4, 1948 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D. C.

18. Funeral director: Warner E. Pumphrey

Address: 8434 Ga. Ave., Silver Spring, Md.

19. Nov. 2 1948 Josephine M. Schaffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 2 1948, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med. Exam 19 to 19 and that I last saw h alive on 19

Immediate cause of death: Coronary occlusion — DURATION: Sudden

Due to: Hard drinking

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhart M.D. Dep Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed: 11-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

ITEMS: 6a and b: doctor's letter filmed G124 2-15-50 L
*Aff. filmed 3-9-50 G
124. L

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21 4

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 8918 1st Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8918 1st Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Arthur Bertram Claxton, Sr.

3. (b) Social Security Number: 577-05-8471

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: ~~Seperated~~ Married
6.(b) Name of husband or wife: ~~Lovie L.~~ ANNA ROTH CLAXTON
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 16, 1877
8. AGE: Years 71 Months 6 Days 11 If less than one day ..... hrs. ..... min.
9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Builder
11. Industry or business
FATHER 12. Name: Arthur B. Claxton
FATHER 13. Birthplace: Washington, D. C.
MOTHER 14. Maiden name: Martha A. Curby
MOTHER 15. Birthplace: Washington, D. C.
16. Informant: * Mr. Donald M. Heizer
Address: 205 E. Wayne Ave. S. S. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30, 1948 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington, D. C.
18. Funeral director: Warner E. Pumphrey, Inc.
Address: 8434 Ga. Ave. Silver Spring, Md.
19. Nov. 29 1948 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 Nov. 1948, at 1 15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Nov. 1948 to 27 Nov. 1948 and that I last saw him alive on 26 Nov. 1948

	DURATION
Immediate cause of death: Coronary thrombosis	1 hr.
Due to: Arteriosclerosis Generalized.	8-10 yrs.
Due to:	
Other conditions: Convalescent from Lobar Pneumonia. (Include pregnancy within 3 months of death)	

Major findings of operations: —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. B. Queen M.D.
M. D. or other
Address: 112 Willow Ave. Takoma Park, Md. Date signed 29 Nov 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11554

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157 e

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Birth 11-18-48

Hospital, Institution, or street address where death occurred:
Suburban Hospital Old Geo. Rd.

How long in hospital or institution? Birth

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Germantown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ~~[illegible]~~ Thomas Clipper

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced: —

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 18 - 1948

8. AGE: Years | Months | Days: 6 | If less than one day: 2 hrs. 20 min.

9. Birthplace: Bethesda Montgomery, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Lewis Brooks
13. Birthplace: Germantown Maryland.

MOTHER
14. Maiden name: Virginia Brewer Clipper
15. Birthplace: Germantown, Maryland.

16. Informant

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 11 29 48 (month) (day) (year)

Cemetery or crematory: SUBURBAN HOSPITAL

Location: Bethesda MD

18. Funeral director: A. B. Salon Supt

Address: Bethesda, Md

19. 12-4 1948 (Date rec'd by registrar) H. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1948 at 9.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 18 1948 to NOV. 24 1948 and that I last saw h. LM alive on NOV. 24 1948

Immediate cause of death: MULTIPLE CARDIAC MALFORMATIONS — DURATION

Due to: CONGENITAL ANOMALIES

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: AORTIC STENOSIS, CLEFT PALATE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Ira W. Pearlman M.D. M. D. or other

Address: Suburban Hosp. Bethesda, Md. Date signed: 11-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11555

46a

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park - Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 48 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 801 Greenwood Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Connelly Mr Stephen Francis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs Susie Elliott Connelly

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 6. 1868

8. AGE: Years: 80 Months: 3 Days: 24 If less than one day ..... hrs. ..... min.

9. Birthplace: Syracuse New York (Town, county, and state)

10. Usual occupation: Policeman

11. Industry or business: Retired

FATHER 12. Name: Barthol mew Connelly

13. Birthplace: Ireland

MOTHER 14. Maiden name: Elizabeth Bailey

15. Birthplace: Quebec Canada

16. Informant: Washington San & Hosp. records

Address: Takoma Park - Maryland.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec 2 1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill Crematory

Location: Foot of Pa. Ave. S.E. at Dist Line, Wash. D.C.

18. Funeral director: J. Arthur Walters

Address: 254 Carroll St. NW. Takoma Park, D.C.

19. Nov. 30 1948 J. Wilm Dodd (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30 1948 at 4:46 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/21/48 to 11/30/48 and that I last saw him alive on 11/28/48

	DURATION
Immediate cause of death: Adeno Carcinoma of Colon	?
Due to: with Metastasis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Colostomy 10/19/48 Amputation of Right Leg above Knee Date of op. 10/20/48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard T. Brown M.D. M. D. or other

Address: 28 Cowgill Ave Takoma Park, Md. Date signed 11/30/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11556

CERTIFICATE OF DEATH

Reg. Dist. No. 2235

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred: Washington Sanitorium & Hosp.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6904 Sycamore ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs Emma A. Cuit

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cau.	widowed

6.(b) Name of husband or wife: Walter W. Cuit

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 20, 1873

8. AGE:

Years	Months	Days	If less than one day
75	6	17	..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER

12. Name: John T. Ferry

13. Birthplace: Washington D.C.

MOTHER

14. Maiden name: Sarah Ann Tyler

15. Birthplace: Baltimore, Maryland

16. Informant: Mrs Grace Ellis (daughter)

Address: 6904 Sycamore ave Takoma Park Md

17. Burial: [redacted] Date thereof: Nov. 15 1948 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory: Rock Creek Cemetery

Location: Wash - D.C.

18. Funeral director: J. Arthur Masters

Address: 254 Carroll St Takoma Park D.C.

19. Nov 11 1948 J. Wm. Doll

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-11 1948, at 3:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 12 1947 to 11-11 1948 and that I last saw h.e.r. alive on 11-11 1948

Immediate cause of death: acute cardiac failure — DURATION

Due to: asteric sclerotic

Due to: Heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dean W. Harding M.D. M. D. or other

Address: 113 Carroll St NW Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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11557

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day.

Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Prince Georges.

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5-317 Freeway Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isan Julius Dalstrom

3.(b) Social Security Number

4. Sex: Male

5. Color or race: Canc.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Harriert E. Dalstrom

6.(c) If alive, give age: 42. years

7. Birth date of deceased (mo., day, yr.): Dec. 25-1900

8. AGE: Years: 47 Months: 11 Days: 26 If less than one day: hrs. min.

9. Birthplace: Kendallville Iowa
(Town, county, and state)

10. Usual occupation: Fire-chief

11. Industry or business: Fireman

FATHER
12. Name: John Henry Dalstrom
13. Birthplace: Iowa

MOTHER
14. Maiden name: Rilda Larson
15. Birthplace: Minn.

16. Informant: Pt's chart

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 2 1948 (month) (day) (year)

Cemetery or crematory: Arlington Natl Cemetery

Location: Arlington Va

18. Funeral director: The S. H. Hines Co. #126

Address: 2901-14th Street, N.W.

19. Nov. 29 1948 (Date rec'd by registrar) J. W. Wadlow Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29, 1948 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29, 1948 to Nov. 29, 1948 and that I last saw him alive on Nov. 29, 1948

Immediate cause of death	DURATION
Acute uremia,	2-3 d.
underlying cause: Prot. Alcoholism.	
Due to	
Due to	
Other conditions: Pneumonia, Lobular	2-3 d.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul V. Starr, M.D. M. D. or other

Address: Takoma Park, Md. Date signed 11-29-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

56 b

11558

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days.
Hospital, Institution, or street address where death occurred: Montgomery County General Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Mrs. Edith Captolla DARNE

3. (b) Social Security Number:

4. Sex: F
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married.
6.(b) Name of husband ~~or wife~~: Samuel W. Darne
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec. 19, 1885
8. AGE: Years 62 | Months 11 | Days 28 | If less than one day ..... hrs. ..... min.
9. Birthplace: Lovettsville Va. (Town, county, and state)
10. Usual occupation: housewife.
11. Industry or business: —
FATHER 12. Name: Mr. Chas. H. Ball
FATHER 13. Birthplace: Va
MOTHER 14. Maiden name: Mrs Jane Keys
MOTHER 15. Birthplace: Va
16. Informant: ~~Hosp.~~ records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 21, 1948 (month) (day) (year)
Cemetery or crematory: Chestnut Grove
Location: Herndon Virginia
18. Funeral director: Money & King
Address: Vienna. Va.
19. Nov. 24 1948 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21 1948 at 3 40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1948 to Nov. 21 1948 and that I last saw her alive on Nov. 21 1948

	DURATION
Immediate cause of death: Coronary thrombosis.	10 hours.
Due to: Coronary sclerosis.	years.
Due to:	
Other conditions: Fibromyomata Uteri - bleeding - surgical removal of. (Include pregnancy within 3 months of death)	years.

Major findings of operation: Degenerating and bleeding Fibromyomata Uteri. Date of op. 11/18/48
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Richard A. Yates M.D. M. D. or other
Address: RFD #1 Silver Spring, Md. Date signed: 11/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164 lb

CERTIFICATE OF DEATH

11559

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 1 day 8 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Middle Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William George Diggs

3.(b) Social Security Number

4. Sex: male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: none

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct. 2, 1906

8. AGE: Years 42 Months 1 Days 13 If less than one day ... hrs. ... min.

9. Birthplace: Maryland, Montg. Co. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Williams Diggs

13. Birthplace: Maryland

MOTHER 14. Maiden name: Louisa Brown

15. Birthplace: Md.

16. Informant: Paul W. Diggs (Son)

Address: 515-7th. St. Co. H. Knoxville Ky.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18, 1948 (month) (day) (year)

Cemetery or crematory: Lincoln Park.

Location: Rockville, Md.

18. Funeral director: Robert L. Snowden

Address: Rockville, Md.

19. 11/18 1948 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 15 1948 at 6:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1948 to 19 and that I last saw h alive on 19

Immediate cause of death: Hemorrhage

Due to: bullet wound thru liver and spleen — DURATION: 42 hrs.

Due to: 22 bullet

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: homicide Date of: 11-13-48

Where did injury occur? Rockville (City or town) Monty (County) Md. (State)

Injured at home, farm, industry, public place (where?): home of friend

Means of injury: 22 rifle Injured at work? no

23. SIGNATURE: Frank J. Bronstart M.D. M. D. or other

Address: Gaithersburg Md. Date signed: 11-15-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11560

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Edmonston (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Edmonston (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rev. John Wesley Dockett

3. (b) Social Security Number none

4. Sex Male

5. Color or race Colored

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife: Estella Dockett.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1870

8. AGE: Years 78 Months 6 Days 24 If less than one day hrs. min.

9. Birthplace Mullingham, Md. Prince George Co. (Town, county, and state)

10. Usual occupation Minister

11. Industry or business

FATHER

12. Name Frederick Dockett

13. Birthplace Maryland

MOTHER

14. Maiden name Martha Ann Weems

15. Birthplace Maryland

16. Informant Estella Dockett

Address Tuckers Lane, Edmonston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 9 1948 (month) (day) (year)

Cemetery or crematory Brooks Chapel

Location Crosme, Maryland

18. Funeral director Robert L. Snowden

Address 246-A- Wash. St. Rockville, Md

19. Nov 8 1948 Gertrude B Fowler (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1948 at 5:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22 1947 to Nov. 6 1948 and that I last saw him alive on November 5 1948

Immediate cause of death: Cardiorenal Disease with Edema

Due to: Adenoma Prostate

Due to: Surgical Removal

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Webster Jewell, M.D. M. D. or other

Address Forbush Md Date signed Nov. 8 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83C

11562

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
10,000 Ga., Ave., Silver Spring, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 38 Duvall Drive, Westmoreland Hills, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MARTHA ELIZABETH DOUGLAS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Sandwith B. Douglas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1868

8. AGE: Years: 80 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Union, Ky.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Joseph E. Weaver,
13. Birthplace: Union, Ky.

MOTHER
14. Maiden name: Catherine E. Riley
15. Birthplace: Union, Ky.

16. Informant: Mrs. Edith Douglas Bergelt,
Address: # 38 Duvall Drive, Westmoreland Hills

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 2, 1948 (month) (day) (year) Md.

Cemetery or crematory: Blue Ash, Ohio

Location:

18. Funeral director: Cherry Chase Funeral Home
Address: 5103 Wis., Ave., N.W.

19. Nov. 1 (Date rec'd by registrar) 19 48 Josephine M. Schaeffe (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1, 19 48 at 9:20 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 19 47 to Nov. 1, 19 48 and that I last saw h E R alive on Oct. 31, 19 48

Immediate cause of death	DURATION
Cerebral Malaeca	1 year
Due to: Cerebral arteriosclerosis.	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank S. Bacon M.D.
M. D. or other

Address: 4828 - Rodman St. Date signed: Nov. 1, 19 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11563

61

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: OLNEY

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 48 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: Montgomery

City or town: BURTONSVILLE

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Maybelle C. Douglass

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Hart N. Douglass

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 4, 1875

8. AGE:

Years	Months	Days	If less than one day
73	9	15	hrs. min.

9. Birthplace: Spencerville MARYLAND (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: FRANK P. CHANEY

13. Birthplace: Ann ARUNDLE MARYLAND

MOTHER

14. Maiden name: JULIE BEAN

15. Birthplace: Ann ARUNDLE MARYLAND

16. Informant: HOSPITAL RECORDS

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 22 1948 (month) (day) (year)

Cemetery or ~~crematory~~: Burtonsville Union

Location: Burtonsville Md

18. Funeral director: Walter E. Pumphrey

Address: Silver Spring, Md

19. Nov 20 1948 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 1948, at 4:39 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/19 1948 to 11/19 1948 and that I last saw him alive on 11/18 1948

Immediate cause of death: Acute Cardiac Failure

DURATION: 1 day

Due to: Coronary Sclerosis

Due to:

Other conditions: Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? —

23. SIGNATURE: [signature] M.D. (M. D. or other)

Address: Sandy Spring, Md Date signed 11/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

64

11561

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Georgia County:

City or town: Waycross
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2008 El Josa St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
DOUGHTY, Margaret Elizabeth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18, 1948

8. AGE:

Years	Months	Days	If less than one day
	7	4	hrs. min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: DOUGHTY, Arthur W.
13. Birthplace: S.C.

MOTHER
14. Maiden name: BECKETT, Nina
15. Birthplace: S.C.

16. Informant: Father: Mr. Arthur W. Doughty
Address: 2008 El Josa St., Waycross, Ga.

17. burial - Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 23, 1948 (month) (day) (year)

Cemetery or crematory: —

Location: Waycross, Ga. - (Hinson) Fun. Home

18. Funeral director: W. W. CHAMBERS
Address: Georgetown, D.C.

19. 11-22- 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 November 1948 at 1:05P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 November 1948 to 22 November 1948 and that I last saw her alive on 22 November 1948

Immediate cause of death: Status Lymphaticus — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Right Subdural Hygroma
Date of op. 11-22-48

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John C. McNerney
J. C. McNerney CDR MC USN
M. D. or other

Address: USNH, Bethesda, Md. Date signed: 11-23-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11564

83a

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg, Md, (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Archie Willis Eader

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Margaret G Eader

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 10th 1880

8. AGE: Years 68 | Months 9 | Days 15 | If less than one day: hrs. min.

9. Birthplace: Pa,
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER 12. Name: John Eader
13. Birthplace: Pa,

MOTHER 14. Maiden name: Susan Kanode
15. Birthplace: Pa,

16. Informant: Michael Eader, Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 11/26/48 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg Md,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md,

19. Nov 26 1948 (Date rec'd by registrar) Ethelda L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24th 1948 at 4.05AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947, to Nov 24 1948 and that I last saw him alive on Nov 22 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to: Hypertension	4 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. J. Bernhard M.D. M. D. or other

Address: Gaithersburg md Date signed 11-24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11565

95C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 414

1. PLACE OF DEATH:
County: 8610 Mayfair Pl
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Mont.
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8610 Mayfair Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3. (a) FULL NAME: George Vernon Earnshaw

3. (b) Social Security Number:

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Clara Earnshaw
6.(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): May 5 1877
(May 5 1877)

8. AGE: Years: 71 Months: Days: If less than one day: hrs. min.

9. Birthplace: Wash DC (Town, county, and state)
10. Usual occupation: Bank Employee
11. Industry or business:
FATHER 12. Name: Richard Earnshaw
FATHER 13. Birthplace: Prince Geo Co. Md
MOTHER 14. Maiden name: Alice King
MOTHER 15. Birthplace: Wash D.C.
16. Informant: George B Earnshaw
Address: 707 McNeill St
17. Burial (Burial, cremation, or removal, which?) Date thereof: Nov 20, 1948 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location: Prince Geo Co Md.
18. Funeral director: S H Hines Co
Address: 2901 14th St N.W.
19. Nov. 17 1948 (Date rec'd by registrar) Josephine M. Schoepf Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 1948 at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1930 to Nov 16 1948 and that I last saw him alive on Nov 1 1948

Immediate cause of death	DURATION
Acute Cardiac Dilatation	5 min
Due to: Cardiac Asthma	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W B Waldron MD M. D. or other
Address: 837 Bonifant St Silver Spring
Date signed: Nov 16, 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11566

93d

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery County
City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Wash. Sem + Hospital, Takoma Pk. Md.
How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1012 Flower ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Byrd Eastham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Cauc.	Married

6.(b) Name of husband or wife: Louise Margaret Eastham
6.(c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.): March 28, 1868

8. AGE: Years 80 | Months 7 | Days 10 | If less than one day ... hrs. ... min.

9. Birthplace: Harrisonburg Va.
(Town, county, and state)
10. Usual occupation: Machinist (Retired).
11. Industry or business

FATHER
12. Name: Phillip Eastham
13. Birthplace: Virginia.

MOTHER
14. Maiden name: Annie Eastham
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: W.S.H. Takoma Park Md.

17. [illegible] (Burial, cremation, or removal. Which?) Date thereof 11-9-48. (month) (day) (year)
Cemetery or crematory: [illegible] Va.
Location
18. Funeral director: Chas. Chase Funeral Home
Address: 5203 Wis. Ave. N.W.

19. 11/8 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7th 1948 at 10 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1948 to Nov. 6 1948 and that I last saw h. alive on November 6 1948

Immediate cause of death: Cerebral hemorrhage left — DURATION 5 days

Due to: Arteriosclerosis, generalized severe — years

Due to:

Other conditions: Coronary sclerosis severe with myocardial fibrosis — Five months +.
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Cerebral hemorrhage; Coronary sclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. N. Mook M.D. M. D. or other
Address: Takoma Park Md. Date signed 11-7-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11567

132

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos 16 days

Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 2 mos. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Columbia County: D. C.

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7 1808 45th St N.W., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME
Mr Frederick August Eberly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1890

8. AGE: Years	Months	Days	If less than one day
58	9	15	19 hrs. 15 min.

9. Birthplace: District of Columbia, Washington
(Town, county, and state)

10. Usual occupation: Retired Gov. Employee

11. Industry or business

FATHER
12. Name: August F. Eberly
13. Birthplace: D.C.

MOTHER
14. Maiden name: Mary Johnson
15. Birthplace: D.C.

16. Informant: Hospital Records

Address: Washington Sanitarium & Hosp. Takoma Pk, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11-23-48 (month) (day) (year)

Cemetery or crematory: Rock Creek Cem.

Location: Washington, D.C.

18. Funeral director: Joseph Gawler's Sons

Address: 1756 Penna. Ave. N.W.

19. NOV 23 1948 (Date rec'd by registrar) J. Wilson Hodd. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 19 48 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6, 1948 19 to Nov. 22 19 48 and that I last saw him alive on Nov. 22 19 48

Immediate cause of death: Uremia; underlying cause: Probably tubular nephritis — Duration: 2 mos 16 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul V. Stearns, M.D. M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

(I)

11568

131b

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME Albert Ross Edmonston Sr.

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Mary Edmonston

6.(c) If alive, give age: Dec. years

7. Birth date of deceased (mo., day, yr.): July 8, 1878

8. AGE: Years 70 Months 4 Days 7 If less than one day ... hrs. ... min.

9. Birthplace: Rockville, Maryland
(Town, county, and state)

10. Usual occupation: Retired U. S. Govt.

11. Industry or business: U. S. Govt.

FATHER
12. Name: John Edmonston
13. Birthplace: Brookville, Maryland

MOTHER
14. Maiden name: Harriet D. Holt
15. Birthplace: Maryland

16. Informant: W. Brooke Edmonston

Address: Rockville, RFD, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18, 1948 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda, Maryland

19. 11-17 1948 (Date rec'd by registrar) W. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 15 1948, at 1.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 11 1948 to Nov 13 1948 and that I last saw alive on Nov 13 1948

Immediate cause of death: Chronic myocarditis

Due to:

Due to:

Other conditions: Chronic nephritis

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. E. Hawks M.D. M. D. or other

Address: Rockville Md Date signed 11/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

56a

11569

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 1 hr. 25 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County:

City or town: Shepherdstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME
Mrs Janie Maude Eichelberger

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	cauc.	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1875

8. AGE:

Years	Months	Days	If less than one day
73	3	17	19 hrs. 55 min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Homemaker

11. Industry or business

FATHER
12. Name: Robert Botteler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Marshall
15. Birthplace: Maryland

16. Informant: Hospital Record

Address: Washington Sanitarium & Hosp, Takoma Pk

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 17, 1948 (month) (day) (year)

Cemetery or crematory: St. Mark's Cemetery

Location: Petersville, Md.

18. Funeral director: Warner E. Pumphrey, Inc.

Address: 8434 Georgia Ave., Silver Spring, Md.

19. Nov. 15 1948 (Date rec'd by registrar) J. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14 1948 at 7:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13 1948 to Nov 14 1948 and that I last saw her alive on Nov 14 1948

Immediate cause of death	DURATION
Acute hemorrhagic pancreatitis	
Due to —	
Due to	
Other conditions: Cyst of r. ovary	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy result: Acute pancreatitis hemorrhagic

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other

Address: Silver Spring, Md. Date signed 11-15-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 11570

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:
Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4547 Montgomery Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME
FREDERICK MILTON EISENSTEIN

3. (b) Social Security Number
None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Agatha Eisenstein

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): October 28, 1882

8. AGE: Years 66 | Months 0 | Days 22 | If less than one day: hrs. min.

9. Birthplace: Sidney, Ohio
(Town, county, and state)

10. Usual occupation: Retired Gov't Employee

11. Industry or business: U. S. Gov't

FATHER
12. Name: Charles F. Eisenstein
13. Birthplace: Sidney, Ohio

MOTHER
14. Maiden name: Mary Renold
15. Birthplace: Sidney, Ohio

16. Informant: Mrs. Agatha Eisenstein
Address: 4547 Montgomery Ave, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 23, 1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Washington, D. C.

18. Funeral director: Wm Reuben Humphrey

Address: Bethesda, Maryland

19. 11-23 1948 (Date rec'd by registrar) W E Obe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1948 at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 7 1947 to November 20 1948 and that I last saw him alive on November 19 1948

Immediate cause of death	DURATION
Coronary Thrombosis	1/2 hour
Due to: Arteriosclerotic heart disease	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bruce T. Benjamin M.D. M. D. or other

Address: 4710 Glenbrook Parkway, Bethesda, Maryland Date signed: 11-22-48

Wis 2123

4710 GLENBAK PARKWAY

11571

94a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr.

Hospital, institution, or street address where death occurred:

501 Tulip Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 ~~Tuc~~ Cedar Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3. (a) FULL NAME ALBERT ERNEST EVA.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 9, 1871

8. AGE:

Years	Months	Days	If less than one day
77	4	7	hrs. min.

9. Birthplace: Cornwall, England (Town, county, and state)

10. Usual occupation: Retired Blacksmith & Painter

11. Industry or business: Home

FATHER

12. Name: Samuel Eva

13. Birthplace: England

MOTHER

14. Maiden name: Elizabeth Ann Richards

15. Birthplace: England

16. Informant: Mrs. Leslie Eva

Address: 115 Sherman Ave. Tak. Park. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18 1948. (month) (day) (year)

Cemetery or crematory: George Mack. Memorial

Location: Riggs Park

18. Funeral director: J. Arthur Walters

Address: 754 Eye St. N.W. Wash. D.C.

19. 11/16 1948 J. Wilm Dodd

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 1948 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1948 to 1948 and that I last saw h. alive on 1948

Immediate cause of death: Coronary occlusion

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
[illegible]
[illegible]

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Trust J. Brockert M.D. Dec. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed 11-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11573

186a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Monty

City or town: Olney (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one year

Hospital, Institution, or street address where death occurred: Monty. C. Gen Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: W. Va. County: Berkeley

City or town: Martinsburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 701 Faulkner St. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Catherine C. Files

3.(b) Social Security Number: 232-36-8487

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sep. 14, 1922

8. AGE: Years: 26 Months: 2 Days: 13 If less than one day: hrs. min.

9. Birthplace: Berkeley Co. W. Va. (Town, county, and state)

10. Usual occupation: Laboratory Technician

11. Industry or business: Hospital

FATHER: 12. Name: Harry M. Files 13. Birthplace: Hurax Va.

MOTHER: 14. Maiden name: Bruce Durham 15. Birthplace: Berkeley Co W. Va.

16. Informant: Harry M. Files Address: Martinsburg W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30, 48 (month) (day) (year)

Cemetery or crematory: Rosedale Location: Martinsburg W. Va.

18. Funeral director: Howard K. Brown Address: Martinsburg W. Va.

19. Nov. 27, 1948 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1948 to Nov. 1948 and that I last saw him alive on 19

Immediate cause of death: Asphyxia

Due to: Epileptic seizure

Due to: Accidental fall in toilet room of hosp. with head injury

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: Found dead

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Acc. Date of: 11/27/48

Where did injury occur? (City or town) Monty Co. (County) (State)

Injured at home, farm, industry, public place (where?): hospital

Means of injury: fall Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other

Address: Gaithersburg Md. Date signed: 11-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS AUG 9-43-15M

11574

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83b

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6413 Ridgewood Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME

ELLA ROOT FITZPATRICK

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James Fitzpatrick

6.(c) If alive, give age: Dec. years

7. Birth date of deceased (mo., day, yr.): July 26, 1857

8. AGE: Years	Months	Days	If less than one day
91 (91)	3	25	hrs. min.

9. Birthplace: Clinton Corners, New York
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: Housewife

FATHER
12. Name: George Root
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sarah Warren
15. Birthplace: Unknown

16. Informant: Gracella Hobley

Address: 6413 Ridgewood Ave., Ch.Ch.Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 24, 1948 (month) (day) (year)

Cemetery or crematory: Potomac Church Cemetery

Location: Potomac, Md.

18. Funeral director: Wm Reuben Humphreys

Address: Bethesda, Maryland

19. 11-22 1948 (Date rec'd by registrar) J E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1948 at 1000p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to 21 Nov 1948 and that I last saw her alive on 17 November 1948

Immediate cause of death: Cerebral Thrombosis — DURATION: 5 days
Right, with left hemiplegia

Due to

Due to

Other conditions: Arteriosclerosis, general

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Stewart Lloyd, M.D. M. D. or other

Address: 3421 Argyle St. N.W. Date signed: 11 21 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11575

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Norbeck.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ yrs.
Hospital, institution, or street address where death occurred: 174 Carrollton Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Washington
City or town: Hagerstown.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 E. Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frank M. Gallagher

3.(b) Social Security Number: 214-09-0262

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mable V. Gallagher
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Sept 15, 1899.

8. AGE:

Years	Months	Days	If less than one day
49	2		hrs. min.

9. Birthplace: Hagerstown, Md.
(Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: Air Plane Industry

FATHER
12. Name: Edward F. Gallagher
13. Birthplace: Fidlersburg, Md.

MOTHER
14. Maiden name: Mame S. Gallagher
15. Birthplace: Hagerstown, Md.

16. Informant: Mrs. Dallas Grady
Address: 174 Callorton Rd. Norbeck Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 30 1948 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md

18. Funeral director: C M Suter & Sons
Address: 305 N Potomac St. Hagerstown Md

19. 11-27 1948 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 1948 at 6 40 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948 to Nov 1948 and that I last saw him alive on Nov. 27 1948

Immediate cause of death: Carcinoma of Prostrate with metastases

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank G. Curlie M.D. or other
Address: 824 8th ave Silver Spring Md Date signed: Nov 29, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164C

11576

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 650 Beall Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME Jackson T. Gibbs

3. (b) Social Security Number 577-18-2336

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Frances Gibbs

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 18, 1919

8. AGE: Years 29 | Months 5 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Robert H. Gibbs
13. Birthplace: Virginia

MOTHER
14. Maiden name: Eunice Yowell
15. Birthplace: Virginia

16. Informant: Mrs Frances Gibbs

Address: 1733 Kenyon St. N.W. D.C.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Nov 12, 1948 (month) (day) (year)

Cemetery or crematory: Arlington Nat. Cem.

Location: Arlington, Virginia.

18. Funeral director: J. Wm Lee Sons Co.

Address: 300-4th St. N.E. Wash. D.C.

19. 11-10 1948 (Date rec'd by registrar) E Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9 1948 at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam 19.. to early 19.. and that I last saw h.. alive on .....

Immediate cause of death	DURATION
Hemorrhage	
Due to: Shot gun wound in skull	15 min.
suicide	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: 11-9-48

Where did injury occur? Rockville (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: Shot gun Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D. Dep Med Exam. M. D. or other

Address: Gaithersburg Md Date signed: 11-9-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11577

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden death

Hospital, Institution, or street address where death occurred:
7033 Wisconsin Ave., Chevy Chase

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Wash. D.C. County: Montgomery

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3927 New Hampshire Ave., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: Not known

3. (a) FULL NAME: John H. Goldberg

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie Fox

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 18th 1891

8. AGE:

Years	Months	Days	If less than one day
57	6	27	..... hrs. ..... min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Monroe & Paul Goldberg

Address: 5912 14th St., N.W., Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 15 1948 (month) (day) (year)

Cemetery or crematory: Danzansky Funeral Home

Location: 3501 14th St., N.W., Wash. D.C.

18. Funeral director: Bernard Danzansky Funeral

Address: 3501 14th St., N.W., Wash. D.C.

19. 11-16 19 48 (Date rec'd by registrar) M. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 15 1948, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam. case 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Coronary occlusion — DURATION: died suddenly

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D. Deputy Med. Examiner M. D. or other

Address: Gaithersburg Md. Date signed 11-15-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55a 11578

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 12 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 520 G St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME GRIMES, John Otis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 7, 1896

8. AGE: Years	Months	Days	If less than one day
52	4	5	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Standard Oil Company

11. Industry or business:

FATHER
12. Name: GRIMES, John Otis dec
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: PHILLIPS, Susie Bell
15. Birthplace: Md.

16. Informant: neice: Mrs. Barbara Baker
Address: Carvel Beach, Baltimore, 26, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-18-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Wm. J. Nalley W. J. N.

Address: 522 8th St., S.E., Wash., D.C.

19. 11-16 (Date rec'd by registrar) 19 48 Mary C. Patterson (Mary C. Patterson) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 November 19 48, at 11:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 October 19 48 to 15 November 19 48 and that I last saw him alive on 15 November 19 48

Immediate cause of death	DURATION
Malignant Synovioma with massive pulmonary left metastasis	2 yrs
Due to	
Due to Malignant Synovioma Right thight	3 yrs
Other conditions Amputation Right thigh Sangical	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. M. Hanner J. M. HANNER, Cdr. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

115296

Reg. Dist. No. ~~4733~~

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
5515 Smallwood Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Green Acres, Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5515 Smallwood Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

HAMILEEN D. HAINES

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Oscar M. Haines

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 25, 1869

8. AGE: Years	Months	Days	If less than one day
79	7	1	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: David Davidson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Catherine Clark
15. Birthplace: Virginia

16. Informant: Oscar M. Haines, Jr., son

Address: 5515 Smallwood Drive, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 29, 1948 (month) (day) (year)

Cemetery or crematory: Mt. Hebron

Location: Winchester, Frederick Co., Va.

18. Funeral director: Warner E. Pumphrey, Inc.

Address: 8434 Georgia Ave., Silver Spring, Md.

19. 11-28- 19 48 (Date rec'd by registrar) W E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 1948, at 10 55 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943, to November 26 1948; and that I last saw her alive on 11-26-48 19

Immediate cause of death	DURATION
Tuberculous Pneumonia.	7 days.
Chr. Tuberculosis. (Healed)	40 yrs.
Due to Generalized Arteriosclerosis Renal	
Due to Sclerosis.	20 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lynn H. Laughlin M.D. M. D. or other

Address: 8757 Colesville Date signed: 11-26-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

11580

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10-30-48
Hospital, institution, or street address where death occurred: Suburban Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Colesville R. #2, Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Susan Wheeler Hancock

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant.

6.(b) ~~Name of husband or wife~~ Father: Ellwood Buckley Hancock
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Oct. 30, 1948

8. AGE:

Years	Months	Days	If less than one day
—	—	2	hrs. min.

9. Birthplace: Bethesda, Monty., Maryland (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: Ellwood Buckley Hancock
13. Birthplace: Anderson, S.C.

MOTHER
14. Maiden name: Margaret Cannon Smith.
15. Birthplace: Deposit, N.Y.

16. Informant: Husband.
Address: Silver Spring, Md. RD 2

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Nov 3 1948 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Maryland
18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. 11-4 1948 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20D. DATE OF DEATH: Nov 2nd 1948 at 12:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 30 1948 to Nov. 2 1948 and that I last saw her alive on Nov. 1 1948

Immediate cause of death	DURATION
Prematurity (7 mos)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank G. Lesher M. D. or other
Address: Silver Spring Md Date signed 11/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville —

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life —

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lincoln Park —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME Raymond James Hawkins —

3. (b) Social Security Number ?

4. Sex: Male

5. Color or race: colored

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Mabel Hawkins

8.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): May 18, 1915

8. AGE: Years 33 Months 4 Days 19 If less than one day ... hrs. ... min.

9. Birthplace: Rockville, Mont, Md. (Town, county, and state)

10. Usual occupation: Laborer —

11. Industry or business

FATHER

12. Name: Hillery Hawkins

13. Birthplace: Maryland —

MOTHER

14. Maiden name: Alice Bowman

15. Birthplace: Maryland —

16. Informant: Mabel Hawkins, wife

Address: Lincoln Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 10 1948 (month) (day) (year)

Cemetery or crematory:

Location: Lincoln Park Rockville Md

18. Funeral director: Robert L. Snowden

Address: Rockville Md

19. 11-10 1948 (Date rec'd by registrar) E R Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/7/48 1948 at 7:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/21 1948 to 11/7 1948 and that I last saw him alive on 11/7/ 1948

Immediate cause of death: Lobar pneumonia —

Due to: Unknown illness causing fever of 6 months

Due to: Duration, loss of wt, thought to be tuberculosis

Other conditions: Diagnosis awaits study of tissue sections —

(Include pregnancy within 3 months of death)

DURATION: 12 hours

Major findings of operations: Date of op.:

Autopsy results: As above —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wallace Wehl M.D. M. D. or other

Address: Rockville Date signed 11/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108 11582

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? dead on arrival

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Temple Hills
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5218 Fisher Road, S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWII

3.(a) FULL NAME
HERATH, John Conrad

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 25, 1906

8. AGE: Years: 42 Months: 1 Days: 12 If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: House Painter

11. Industry or business:

FATHER
12. Name: HERATH, John
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine ? dec.
15. Birthplace: Germany

16. Informant: brother: Mr. Henry C. Herath
Address: 212 E. Hamilton Ave., Silver Spring, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-8-48 (month) (day) (year)

Cemetery or crematory: Cedar Hills Cemetery

Location: Suitland, Maryland

18. Funeral director: Arthur E. Simmons, Jr. AE Simmons
Address: 2007 Nichols Ave., SE, Wash. DC

19. 11-7-1948 (Date rec'd by registrar) Mary C. Patterson (Mary C. Patterson) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 7 1948 at 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def. med. Exam. Cang 19 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute myocarditis	3 hrs.
Due to: Lobar pneumonia	7 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: F. J. Broschart
F. Broschart M.D.
Coroner Montgomery County
Address: Gaithersburg, Md. Date signed: 11-7-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

11583

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days and 17 hrs

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 4 days and 17 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7546 Alaska Ave. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mr. Fred A. Herrmann

3.(b) Social Security Number 220-12-3431

4. Sex: M.

5. Color or race: W.

6.(a) ~~Single~~, married, ~~widowed or divorced~~

6.(b) Name of husband or wife: Blanche Herrmann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1876

8. AGE: Years 72 Months 11 Days 7 If less than one day ..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business: Retired

FATHER
12. Name: John F. Herrmann
13. Birthplace: Germany

MOTHER
14. Maiden name: Blanche Ewalt
15. Birthplace: Washington, D.C.

16. Informant: Mrs. Blanche R. Herrmann

Address: 7546 Alaska Ave., N.W., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26, 1948 (month) (day) (year)

Cemetery ~~or crematory~~: Prospect Hill

Location: Washington, D.C.

18. Funeral director: Warnex E. Pumphrey, Inc.

Address: 8434 Georgia Ave., S.S. Md.

19. 11/23 1948 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23rd 1948, at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 MAR. 1948 to 23 NOV. 1948 and that I last saw h.l.m. alive on 22 NOV. 1948

Immediate cause of death	DURATION
CONGESTIVE HEART FAILURE	
Due to: HYPERTENSIVE HEART DISEASE.	
Due to: ARTERIOSCLEROSIS	
Other conditions: RT. INGUINAL HERNIA. LOBAR PNEUMONIA RT. LOWER LOBE	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE

— Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. Marshall Cauffiel Jr. M.D. M. D. or other

Address: 8648 GEORGIA AVE. S.S. Date signed: 23 NOV. 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11584

302

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1520 Kingman Place, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME
HILLARD, Joseph

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 20, 1892

8. AGE: Years	Months	Days	If less than one day
56	6	9	hrs. min.

9. Birthplace: N.C.
(Town, county, and state)

10. Usual occupation: Barmans helper

11. Industry or business

FATHER
12. Name: HILLARD, Wm.
13. Birthplace: N.C.

MOTHER
14. Maiden name: FORESTER, Victoria
15. Birthplace: N.C.

16. Informant: brother: Mr. Samuel Hillard
Address: 1520 Kingman Pl., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5, 1948 (month) (day) (year)
Cemetery or crematory: St. Paul's Baptist
Location: Tarboro, N.C.

18. Funeral director: John T. Rhines
Address: 901 3rd St., S.W., Wash., D.C.

19. 11-30 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 November 19 48, at 2:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 November 19 48, to 29 November 19 48 and that I last saw him alive on 29 November 19 48

Immediate cause of death	DURATION
Valvular Heart Disease, Aortic Insufficiency	5 Mo
Due to: Syphilis, Cardiovascular	31 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Queen
W. F. QUEEN, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

309

11585

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Montg. Co. Gen. Hosp. Olney, Md.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montg.

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 409 Anderson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME John Frank Howard

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 16 - 1870

8. AGE: Years 78 | Months 4 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: –

FATHER
12. Name: Mr. Thomas Howard - Dec.
13. Birthplace: Holland

MOTHER
14. Maiden name: Miss Elizabeth Boyles - Dec.
15. Birthplace: –

16. Informant: Mrs. Rachel Courouniotis
Address: 339 E. 28th St. Balt. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov 9-1948 (month) (day) (year)

Cemetery or crematory: Sallisaw Oklahoma

Location: ~~Bethesda Md~~ Oklahoma

18. Funeral director: Wm. R. Lumsden

Address: Bethesda Md.

19. Nov 9 1948 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1948 to Nov. 9 1948 and that I last saw him alive on Nov. 9 1948.

Immediate cause of death: Arteriosclerosis, hypertension — 10 yrs.
Due to: Myocardial failure — few weeks

Due to:

Other conditions: Syphilis treated latent — 10 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Lathrum, M.D. (M. D. or other)

Address: Rockville, Md. Date signed 11/9/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

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11586

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3357 Stephenson Place, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME HYDE, Mary Penniman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband ~~or wife~~: Ralph Underhill Hyde
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 4, 1899

8. AGE:

Years	Months	Days	If less than one day
49	8	15	hrs. min.

9. Birthplace: S. C. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: PENNIMAN, Gardner B. dec.
13. Birthplace: NYC

MOTHER
14. Maiden name: JOHNSTON, Mary dec.
15. Birthplace: S.C.

16. Informant: husband: Capt. Ralph U. Hyde USN Ret.
Address: 3357 Stephenson Pl., N.W., Wash., D.C.
17. Burial, cremation, or removal. Which?: cremation Date thereof: 11-20-48 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Washington, D. C.
18. Funeral director: W. Reuben Pumphrey Per H.F.W.
Address: 7557 Wisconsin Ave., Bethesda, Md.
19. 11-19-48 (Date rec'd by registrar) 19 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 November 19 48, at 14:58 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 November 19 48, to 19 Nov. 19 48 and that I last saw him alive on 19 November 19 48

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: metastatic carcinoma breast	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Ca left breast & metastatic nodes left cervical Date of op. 1945 + 1948
Autopsy results: confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. J. Luska, Cdr. MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 11-19-48

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11587 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6631 East Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Albert Jervis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Louise K. Jervis

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 10 1871

8. AGE: Years 77 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: New York N Y (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Clerk

FATHER 12. Name: William Jervis

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: Mary Guiss

MOTHER 15. Birthplace: Ireland

16. Informant: Louise K Jervis

Address: 6631 East Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30, 1948 (month) (day) (year)

Cemetery or crematory: Mt Hope

Location: New York N Y

18. Funeral director: Deal Funeral Home

Address: 4812 Ga Ave NW.

19. 11-29 1948 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1948 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27 1948 to Nov. 29 1948 and that I last saw h.s.m. alive on November 29 1948

Immediate cause of death	DURATION
Tuberculous Pneumonia	1 week
Due to: Pulmonary Tuberculosis	12 years
Due to:	
Other conditions: Cerebral Thrombosis	1 month

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert G. Gough M.D. M. D. or other

Address: 106 Del Ray Ave Bethesda Md

Date signed: Nov. 29 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

11588

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Gaithersburg, MD. Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Six weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg, MD, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Henry T. Johnson

3.(b) Social Security Number: No

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Emily R. Johnson

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 14. 1875

8. AGE: Years: 73 Months: 3 Days: 5 If less than one day: hrs. min.

9. Birthplace: Frederick CO. MD. (Town, county, and state)

10. Usual occupation: Labore

11. Industry or business: Nursery

FATHER

12. Name: Samuel Johnson

13. Birthplace: Maryland,

MOTHER

14. Maiden name: Rosie Basford

15. Birthplace: Frederick, CO. MD.

16. Informant: Mrs. Harvey Reed

Address: Gaithersburg, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 22.1948 (month) (day) (year)

Cemetery or crematory: Mountain Chapel

Location: Comus MD.

18. Funeral director: Roy W. Barber

Address: Laytonsville, MD.

19. Nov 21 1948 (Date rec'd by registrar) Abada G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19 1948, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1948, to Nov 16 1948 and that I last saw h. alive on Nov 16 1948

Immediate cause of death: Coronary thrombosis — DURATION

Due to: arteriosclerosis

Due to:

Other conditions: Hemiplegia sinistra

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D. (M. D. or other)

Address: Gaithersburg Md. Date signed: Nov 21 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

11589

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:
202 East Glenbrook Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 202 East Glenbrook Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: BERTHA ELTHEAR JONES

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Fletcher H. Jones

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 13, 1889

8. AGE: Years	Months	Days	If less than one day
59	6	8	____ hrs. ____ min.

9. Birthplace: Montgomery county, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Michael H. Sullivan
13. Birthplace: New York City, New York

MOTHER
14. Maiden name: Mary E. ____?
15. Birthplace: Penna.

16. Informant: Fletcher H. Jones

Address: 202 East Glenbrook Rd., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 23/48 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland, Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda, Maryland

19. Nov 23 1948 (Date rec'd by registrar) M. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21, 1948 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1947 to Nov 20 1948 and that I last saw her alive on Nov 20 1948

Immediate cause of death: Gunshot carcinomatosis — DURATION 1 yr
c̄ Terminal Pneumonia — 2 da.
Due to: Carcinoma of Breast — 5 yr.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Breast with Metastasis Date of op. 5 yr ago

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William H. Ort M. D.

Address: 1835 Eye St. N.W. Date signed 11-21-48

PLEASE PRINT, WRITE LEGIBLY. Physicians: please write the causes of death clearly and legibly. is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11590

46d

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? Nine days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 Westmoreland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JONES, HELEN BAILEY

3.(b) Social Security Number

4. Sex: Female (Female)

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Roy Wesley Jones

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 20, 1897

8. AGE: Years 51 | Months 4 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace: James Ville, North Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: John H. Bailey

13. Birthplace: North Carolina

MOTHER

14. Maiden name: Mary Frances Calloway

15. Birthplace: North Carolina

16. Informant: patient's Chart

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/19/48 (month) (day) (year)

Cemetery or crematory: Forest Lawn Cem.

Location: Norfolk, Va.

18. Funeral director: J. Arthur Walters

Address: 254 Carroll St N.W. Wash. D.C.

19. 11/16 1948 (Date rec'd by registrar) J. Wm. Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1948 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to 11/16 1948

and that I last saw her alive on 11/16 1948

Immediate cause of death: Adeno carcinoma of rectum with metastases — DURATION: 3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of rectum removed — Date of op. 2 yrs ago

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Howard F. Moore M.D. M. D. or other

Address: 28 Carroll Ave Takoma Park — Date signed 11/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

CERTIFICATE OF DEATH

11572

Reg. Dist. No. 22.3

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3048 Monroe St. N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Kerwin Mrs Mary Evelyn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Kerwin, Mr John D

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 8, 1907

8. AGE:

Years	Months	Days	If less than one day
40	11	14	hrs. min.

9. Birthplace: Cambridge, Maryland
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Burton, Charles W.
13. Birthplace: Maryland

MOTHER
14. Maiden name: Smith, Sarah Elizabeth
15. Birthplace: Maryland

16. Informant: Washington Sanitarium Records

Address

17. Removal. (Burial, cremation, or removal. Which?) Date thereof 11/19/48 (month) (day) (year)

Cemetery or crematory

Location: Hyattsville Md

18. Funeral director: Gorsuch & Son

Address: Hyattsville Md

19. 11/19 1948 (Date rec'd by registrar) J. Wm. Doak Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 1948 at 12:38 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1948 to Nov. 19 1948 and that I last saw him alive on November 19 1948

Immediate cause of death: Metastatic Bronchogenic Carcinoma left upper lobe — Duration: 2 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Left lung removed

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lynwood Baughman DMD. M. D. or other

Address: 8252 Pa Ave. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161a

11591

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: The Montgomery County General Hospital

How long in hospital or institution? 5 hrs 15 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Damascus (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ROBERT WAYNE King

3. (b) Social Security Number

4. Sex: MALE

5. Color or race: White

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 19 1948

8. AGE: Years | Months | Days | If less than one day: 4 hrs. min.

9. Birthplace: Olney Montgomery Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Stanley Delaney King

13. Birthplace: Cedar Heights Md

MOTHER 14. Maiden name: Rosa Lee Flynn

15. Birthplace: Cedar Grove Md

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 20/48 (month) (day) (year)

Cemetery or crematory: Salem

Location: Cedar Grove

18. Funeral director: J B Beall Jr

Address: Damascus Md.

19. 11-19 1948 Gertrude B Fowler (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 1948 to November 19 1948 and that I last saw him alive on November 19 1948

Immediate cause of death: Bilateral atelectasis — DURATION 4 hours

Due to: Congenital cirrhosis of the liver — 4 hours

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James F. Kerr M.D. M. D. or other

Address: Damascus, Md. Date signed: 11/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

11592

Reg. Dist. No. 716

1. PLACE OF DEATH:

County: Montgomery

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years

Hospital, Institution, or street address where death occurred: West Saul Rd., Kensington

How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: West Saul Rd.
(If rural, give LOCATION)

2.(a) If veteran name war: No

3. (a) FULL NAME Augustus M. Kline

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Leanore Kline

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept. 27 1877

8. AGE:

Years	Months	Days	If less than one day
71	1	22	...hrs. ...min.

9. Birthplace: Bethesda, Md.
(Town, county, and state)

10. Usual occupation: Caretaker of Farm

11. Industry or business

FATHER
12. Name: UnKnown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Dorothy M. Kline

Address: Rt #5 Spring Lake Rd, Rockville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22/48 (month) (day) (year)

Cemetery or crematory: St Mary's Cemetery

Location: Rockville, Md.

18 Funeral director: Wm Ransom Humphrey

Address: 7557 Wisconsin Ave. Bethesda

19. 11-20 1948 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 19 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep 1948 to Nov 19 1948 and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary occlusion — DURATION: died suddenly

Due to: ...

Due to: ...

Other conditions: ...

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
Dep med Exam, M. D. or other

Address: Gaithersburg Md Date signed 11-19-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

11593

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Potomac
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Potomac RFD Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles E. Langley

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name ~~of husband or~~ wife: Ryenza S.

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): July 7, 1883

8. AGE: Years	Months	Days	If less than one day
65	4	27	hrs. min.

9. Birthplace: Washington
(Town, county, and state)

10. Usual occupation: Railroad Supplies

11. Industry or business

FATHER
12. Name: Charles A. Langley
13. Birthplace: Maine

MOTHER
14. Maiden name: Annie
15. Birthplace: Washington, D.C.

16. Informant: Wife

Address: Same as above

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 6 48 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D.C.

18. Funeral director: Wm. Reuben Pumphrey

Address: 7557 Wisconsin Ave., Bethesda 14, Md.

19. 11-6 1948 (Date rec'd by registrar) E. B. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 4 1948, at 4:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Coronary occlusion

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
Found dead in bed

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D. Dep med Exam · M. D. or other

Address: Gaithersburg Md. Date signed 11-4-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11594

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Montgomery

City or town: Glen Echo Hts

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD. County: MONTGOMERY

City or town: GLEN Echo Hts

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7029 WEHAWKEN Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MAGGIE D. LEONBERGER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	Widowed

6.(b) Name of husband or wife: JOSEPH LEONBERGER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): DEC 12, 1873

8. AGE: Years 74 | Months 11 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace: WASHINGTON D.C (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER 12. Name: LEVI KIDWELL

13. Birthplace: VA.

MOTHER 14. Maiden name: MARGARET

15. Birthplace: UNKNOWN

16. Informant: LILLIAN BUELL

Address: 4726 3rd St. NW

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 23 (month) (day) (year)

Cemetery or crematory: Ft Lincoln Cemetery

Location

18. Funeral director: W. W. Chamberlin Co.

Address: 1400 Chapin St. NW.

19. 11-27 19 48 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21st 19 48 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 19 47 to Nov 20 19 48 and that I last saw h.er alive on Nov. 20. 19 48

Immediate cause of death: Cerebral hemorrhage — DURATION: 2 days

Due to

Due to

Other conditions: Chronic myocarditis — years

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. P. Ryland M.D. M. D. or other

Address: 4401 Mass. Ave NW, Wash 16. DC. Date signed: 11-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

11595

186a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 29 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6107 Broad Branch Road
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME
LLOYD, Howard Franklin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Marshall D. Lloyd

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 12, 1867

8. AGE: Years	Months	Days	If less than one day
81	3	22	____ hrs. ____ min.

9. Birthplace: W.Va.
(Town, county, and state)

10. Usual occupation: Insurance & Bonds

11. Industry or business:

FATHER
12. Name: LLOYD, James dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: DISHMAN, Amelia dec.
15. Birthplace: Va.

16. Informant: wife: Mrs. Marshall D. Lloyd
Address: 6107 Broad Branch Road, N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-8-48 (month) (day) (year)

Cemetery or crematory: Edgehill Cemetery
Location: Charles Town, W.Va.

18. Funeral director: Melvin T. Strider
Address: Charles Town, W.Va.

19. 11-5- 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 November 19 48, at 8:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 July 19 48, to 4 November 19 48 and that I last saw him alive on 4 November 19 48

Immediate cause of death	DURATION
Lobar Pneumonia, hypostatic	
Due to: Inactivity	
Due to: Fracture, left hip	
Other conditions: Acute Cholecystitis; acute Cholangitis	

(Include pregnancy within 3 months of death)

Major findings of operation: Fracture left hip
Date of op. 7-5-48

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 7/5/48

Where did injury occur? Wash. (City or town) D.C. (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fall Injured at work?

23. SIGNATURE: A. B. Dickson
A. B. DICKSON, Lt MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-5-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11596

117a

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 hrs., 40 minutes

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 17 hrs., 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3943 Blaine St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.American

3.(a) FULL NAME
LUSBY, WILLIAM THOMAS

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 23, 1880

8. AGE: Years: 68 Months: 5 Days: 19 If less than one day: hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER
12. Name: LUSBY, William
13. Birthplace: unknown

MOTHER
14. Maiden name: ANGEL, ?
15. Birthplace: unknown

16. Informant: sister: Mrs. Mary E. Redding

Address: 3943 Blaine St., N. E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-16-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers

Address: 1400 Chapin St NW Washington DC

19. 11-12-48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 November 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 1948 to 12 November 1948 and that I last saw him alive on 12 November 1948

Immediate cause of death: peritonitis, generalized — DURATION: 48 hrs.

Due to: gastric ulcer, perforated

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: peritonitis and perforated ulcer — Date of op. 11/12/48

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. A. GROSS, Captain MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-12-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

124b

11597

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 13days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1438 Meridian Place, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME
LYON, Ernest Brakenahl

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25, 1898

8. AGE: Years	Months	Days	If less than one day
50	5	7	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Taxie Driver

11. Industry or business

FATHER
12. Name: LYON, Alfred dec.
13. Birthplace: Md.

MOTHER
14. Maiden name: STONE, Eugene dec.
15. Birthplace: Md.

16. Informant: friend: Mr. James J. Jewell
Address: 808 Burlington Avenue, Silver Spring, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-5-48 (month) (day) (year)

Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS J.D.P.
Address: Georgetown, D. C.

19. 11-2 (Date rec'd by registrar) 19 48 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2 19 48 at 12:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 October 19 48 to 2 November 19 48 and that I last saw him alive on 2 November 19 48

Immediate cause of death	DURATION
Myocardial infarction	
Due to: Coronary Heart Disease, Arteriosclerotic	
Due to:	
Other conditions: Cirrhosis, liver, atrophic and Generalized Arterioslcerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. E. Watters L. E. WATTERS, Lt. (JG) MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

114e

11598

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 10,014 Greenock Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. 10,014 Greenock Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Lewis Mattison

3. (b) Social Security Number ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Nellie Louise Mattison

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1871

8. AGE:

Years	Months	Days	If less than one day
77	2	14	..... hrs. ..... min.

9. Birthplace: White Lake, N. Y. (Town, county, and state)

10. Usual occupation: School Teacher -- (retired)

11. Industry or business

FATHER

12. Name: Lewis Eugene Mattison

13. Birthplace: New York

MOTHER

14. Maiden name: Emma DuBar

15. Birthplace: Maryland

16. Informant: Charles W. Mattison, son

Address: 10,014 Greenock Ave., Silver Spring, Md.

17. Shipment & burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 27, 1948 (month) (day) (year)

Cemetery or crematory: Broadalbin Cemetery

Location: Broadalbin, Fulton Co., N. Y.

18. Funeral director: Warner E. Pumphrey Inc.

Address: 8434 Georgia Ave., Silver Spring, Md.

19. Nov. 27 1948 Josephine Schaeffer (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 1948 at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1948 to November 27 1948 and that I last saw him alive on November 27 1948

Immediate cause of death: Cardiac failure — DURATION: Two years

Due to: Cor pulmonale

Due to: Chronic pulmonary fibrosis

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Barbara Moulton M.D. M. D. or other

Address: 1328 Eye St. N.W. Washington D.C. Date signed: Nov 27 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

VS A15 9-45-15M

(I)

Evidence for change of birth date shown on:

FILM No. G 118 DEC -1 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11593

83 b

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 6 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5031 V St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am.War

3.(a) FULL NAME

MAURY, Magruder Gordon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

8.(b) Name of husband or wife: Jean West Maury

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May ~~23~~, ~~1880~~ 1878

8. AGE: Years	Months	Days	If less than one day
70	~~5~~ 6	~~28~~ 19	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Retired Army

11. Industry or business

FATHER

12. Name: MAURY, Thompson dec.

13. Birthplace: Va.

MOTHER

14. Maiden name: GORDON, Sally dec.

15. Birthplace: Va.

16. Informant: wife: Mrs. Jean W. Maury

Address: 5031 V St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-24-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS J. E. P.

Address: 3072 M St., N. W., Wash., D.C.

19. 11-23-48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 November 1948, at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 October 1948 to 22 November 1948 and that I last saw him alive on 22 November 1948

Immediate cause of death	DURATION
Massive Cerebral Infarction	1 mon.6days
~~Secc~~ Pulmonary Edema, Severe	7days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. Boswell, Lt. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-23-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11600

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 914

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1114 Sale Dr

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hubert Curtis McLeran

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Evelyn W. McLeran

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Aug 16 1898

8. AGE: Years	Months	Days	If less than one day
50	3	1	hrs. min.

9. Birthplace: Tenn. (Town, county, and state)

10. Usual occupation: government clerk

11. Industry or business

FATHER 12. Name: John D. McLeran

13. Birthplace: Tenn

MOTHER 14. Maiden name: Kelina Allen

15. Birthplace: Tenn.

16. Informant: Evelyn W. McLeran

Address: 1114 Sale Dr. Silver Spring Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov 17/48 (month) (day) (year) Nov. 20 1948

Cemetery or crematory: Columbia Gardens Cemetery Arlington Co. Va.

Location: ~~Washington D.C.~~

18. Funeral director: Joseph F. Birch's Sons

Address: 3834 "M" St, N.W.

19. Nov. 17 1948 (Date rec'd by registrar) Josephine E. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 17 1948 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1948 to 19 and that I last saw h alive on 19

Immediate cause of death: Coronary occlusion — DURATION: during sudden

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhart M.D. Sept med Exam. M. D. or other

Address: Gaithersburg Md. Date signed 11-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

11601

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred: Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Grandin Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: JOHN CARSON MILLER

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Low Miller

6.(c) If alive, give age: 31 yrs. years

7. Birth date of deceased (mo., day, yr.): May 30, 1908

8. AGE:

Years	Months	Days	If less than one day
40	5	12	hrs. min.

9. Birthplace: Page Co. Virginia
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Tinning

FATHER
12. Name: Solomon L. Miller
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary A. Fox
15. Birthplace: Virginia

16. Informant: Mrs Minnie L. Miller
Address: 306 Grandin Ave. Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 25, 1948 (month) (day) (year)

Cemetery or crematory: Rileyville

Location: Rileyville, Virginia

18. Funeral director: Wm Reuben Humphrey

Address: Bethesda, Md.

19. 11-25 1948 (Date rec'd by registrar) E. P. Sleeman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 1948, at 6 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 1948, to Nov. 22 1948 and that I last saw h~~im~~ alive on Nov. 22 1948.

Immediate cause of death: Coronary occlusion (thrombosis) — DURATION: 8 days.

Due to: (2nd attack 3 hours before death)

Due to:

Other conditions: None.

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm A. Fridlund M.D. M. D. or other

Address: Rockville, Md. Date signed: 11/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11602

52a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 19 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 Baltimore Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
MILLER, Mary

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 17, 1874

8. AGE: Years	Months	Days	If less than one day
74	1	12	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: DINTZ, Simond dec.
13. Birthplace: Germany

MOTHER
14. Maiden name: WINKLER, Catherine dec.
15. Birthplace: Md.

16. Informant: son: Mr. Gerald Miller
Address: 114 Baltimore Ave., Takoma Park, Md.

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: 11-12-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: J. Arthur Walters
Address: 254 Carroll St., N. W. Wash., D.C.

19. 11-10- 19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 19 48 at 4:25 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 20 July 19 48 to 9 Nov. 19 48 and that I last saw him alive on 9 November 19 48

Immediate cause of death	DURATION
Hypernephroma, left kidney	
Due to: Extreme cachexia	
Due to: Bronchopneumonia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P. L. Bates, Lt. (jg) MS USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-10-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11603

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 1 19 hrs

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 1 day 1 19 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mamie V. Mills

3.(b) Social Security Number

4. Sex: F

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife: Elijah J. Mills

6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): Aug. 3rd 1872

8. AGE: Years 76 Months 3 Days 24 If less than one day ... hrs. ... min.

9. Birthplace (town, county, and state): Point of Rocks Md.

10. Usual occupation: Retired Farmer

11. Industry or business: Farmer

FATHER 12. Name: George Davis

13. Birthplace: Leesburg Va.

MOTHER 14. Maiden name: Lizzie Booth

15. Birthplace: Leesburg Va.

16. Informant: Vernon D. Mills

Address: Gaithersburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1948 (month) (day) (year)

Cemetery or crematory: Forest Oak - Gaithersburg

Location: Gaithersburg, Maryland

18. Funeral director: M. M. Atchison & Son

Address: Frederick, Md.

19. 11-30 19 48 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30th 1948 at 5:16 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1948 to Nov 30 1948 and that I last saw her alive on Nov 29 1948

Immediate cause of death	DURATION
Congestive Heart Failure	1 week
Due to: Hypertensive Cardio-vascular disease	many years
Other conditions: Hypertrophic Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Welch M.D. M. D. or other

Address: Rockville Date signed 11/30/48

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11604

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Sandy Spring Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Sandy Spring Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Charlie V Morris Morris

3.(b) Social Security Number Unknown

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Maude L. Morris
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): May 18-1878
May 18-1878

8. AGE: Years 70 Months 5 Days 18 If less than one day ... hrs. ... min.

9. Birthplace: Green Co Va (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm
FATHER 12. Name: Hillard Morris
13. Birthplace: Green Co Va.
MOTHER 14. Maiden name: Margaret Morris
15. Birthplace: Green Co Va.
16. Informant: Maude L. Morris
Address: Boonsville Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 5-1948 (month) (day) (year)
Cemetery or crematory: Family
Location: Boonsville Va
18. Funeral director: Roy W. Barber
Address: Laytonsville Md
19. Nov 5 1948 (Date rec'd by registrar) Gertrude B Zawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 November 1948, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 Oct 1948 to 5 Nov 1948 and that I last saw him alive on 5 Nov 1948

Immediate cause of death: Cardiorespiratory failure — DURATION: 8 days
Due to: Arteriosclerotic Heart Disease — years
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles V Figley M.D. (M. D. or other)
Address: Sandy Spring Md Date signed: 5 Nov 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11605

83a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
521 Dartmouth Avenue

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city of town limits, write RURAL and give nearest town)

Street No. 521 Dartmouth Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
IVA M. MORRIS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Clarence P. Morris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 25, 1897

8. AGE: Years	Months	Days	If less than one day
50	11	9	..... hrs. ..... min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Thomas Elmore
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Martha House
15. Birthplace: Kentucky

16. Informant: Lt. Col. Clarence P. Morris

Address: 521 Dartmouth Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5, 1948 (month) (day) (year)

Cemetery or crematory: River View Cemetery

Location: Morgantown, Butler Co., Ky.

18. Funeral director: Warner E. Pumphrey

Address: 8434 Ga. Ave., Silver Spring, Md.

19. Nov. 5 (Date rec'd by registrar) 19 48 Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 19 48 at 5:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 5 19 42 to November 4 19 48 and that I last saw her alive on November 3, 19 48

	DURATION
Immediate cause of death: Cerebral Hemorrhage (Right Hemiplegia)	One month
Due to: Arterial Hypertension	8 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: H. H. Howlett M.D.
M.D. or other

Address: 928 Sligo Ave., Silver Spring, Md. Date signed: Nov. 4, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 11606

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ~~[illegible]~~
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? Died on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. 5 Rockville (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Henry Ray

3.(b) Social Security Number

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of ~~husband~~ or wife: Mary Jane
6.(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): Feb. 15th 1875

8. AGE: Years 73 Months 9 Days 3 If less than one day ... hrs. ... min.

9. Birthplace: Rockville, Md. (Town, county, and state)
10. Usual occupation: janitor (Retired)
11. Industry or business
FATHER 12. Name: William Thomas Ray
13. Birthplace: Montgomery Co.
MOTHER 14. Maiden name: Lucretia Shaeffer
15. Birthplace: Pennsylvania
16. Informant: Mrs. Mildred Id. Ray
Address: Washington Grove Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 20 1948 (month) (day) (year)
Cemetery or ~~crematory~~: Rockville Union
Location: Rockville, Md.
18. Funeral director: Warner E. Pumphrey Inc.
Address: 8434 Ga. Ave. Silver Spring, Md.
19. 11-19 1948 (Date rec'd by registrar) H. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-18 1948 at 12:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 8, 1948 to Nov. 18 1948 and that I last saw him alive on Nov. 18, 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	10 days
Due to: Generalized arteriosclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Emil G. Beuerfeld M.D. M. D. or other
Address: Rockville, Md. Date signed 11/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

11617

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:
Suburban Hospital, Bethesda

How long in hospital or institution? 17 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 735 Anderson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME Phillip Reed.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Zelda Reed -

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): September 12, 1883

8. AGE: Years: 65. Months: 2 Days: 15 If less than one day: hrs. min.

9. Birthplace: Darnestown, Maryland.
(Town, county, and state)

10. Usual occupation: Retired Mechanic

11. Industry or business: Auto Mechanic

FATHER
12. Name: Phillip Reed.
13. Birthplace: , Virginia

MOTHER
14. Maiden name: Catherine Thompson
15. Birthplace: , Virginia

16. Informant: Mrs Zelda (Phillip) Reed

Address: Rockville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30, 1948 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville Union, Maryland.

18. Funeral director: Wm. Larsen Funeral

Address: Bethesda Maryland.

19. 11-29 1948 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 1948, at 1 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1947 to 27 Nov 1948 and that I last saw him alive on 26 Nov 1948

	DURATION
Immediate cause of death: Congestive Heart failure -	1 year
Due to: Arteriosclerosis	10 years
Due to: Hypertension	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. W. Murphy M.D. M. D., or other

Address: Rockville Md. Date signed: 28 Nov 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

11608

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1914 G St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
REIFEL, Horace Charles, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 10, 1948

8. AGE: Years	Months	Days	If less than one day
-	3	-	hrs. min.

9. Birthplace: Bethesda, Md., (rural)
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: REIFEL, Horace, Captain USMC Active
13. Birthplace: Tex.

MOTHER
14. Maiden name: RECKETTS, Beverly
15. Birthplace: Washington, D.C.

16. Informant: mother; Mrs. Horace Reifel
Address: 19414 G St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-16-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Joseph Gawler
Address: 1750 Pennsylvania Ave., N.W., Wash., D.C.

19. 11-10 1948 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 November 19 48, at 11:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 October 19 48, to 10 November 19 48 and that I last saw him alive on 10 November 19 48

Immediate cause of death	DURATION
Massive pulmonary atelectasis of right lobes	
Due to: Congenital cyst of left lung - upper lobe	
Due to: Bilateral atelectasis	
Other conditions: Prematurity	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Andrew M. Margileth, A. M. MARGILETH, Lt JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 10-10-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11609

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 105 Lincoln Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Takoma Park,
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 105 Lincoln Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Louis Rey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 15, 1868

8. AGE: Years: 80 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Switzerland
(Town, county, and state)

10. Usual occupation: Florist- Retired

11. Industry or business

FATHER
12. Name: August Rey
13. Birthplace: Switzerland

MOTHER
14. Maiden name: Barbara Stierli
15. Birthplace: Switzerland

16. Informant: Walter J. Rey

Address: 8 E Oakland, Oakland, N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-15-48 (month) (day) (year)

Cemetery or crematory: St Marys

Location: Wash D.C.

18. Funeral director: The S.T. Hines Co

Address: 2901 - 14th St., N.W., Wash. D.C.

19. Nov 13 1948 (Date rec'd by registrar) J. Wilson Dodd Registrar

MEDICAL CERTIFICATION

11/13/48 12 o'c noon

20. DATE OF DEATH: Nov. 13, 1948 at 11 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27, 1948, to Nov. 13, 1948 and that I last saw him alive on Nov. 12, 1948.

Immediate cause of death: arteriosclerosis — DURATION: Indefinite

Due to:

Due to:

Other conditions: Chronic myocarditis — DURATION: "

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Bliss M.D. M. D. or other

Address: 6911 5th St. N.W. Date signed: Nov 13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

11610

Evidence for addition of info. #21 is on: 94a

HLM No. G 119 MAR 21 1949 CERTIFICATE OF DEATH

Reg. Diat. No. 316

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or Institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 608 Monroe St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
MARY H. RICHARDSON

3. (b) Social Security Number
262-03-4211

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 31, 1882

8. AGE: Years: 66 Months: 9 Days: 17 If less than one day: hrs. min.

9. Birthplace: Wade, Ohio
(Town, county, and state)
10. Usual occupation: Registered Phar.
11. Industry or business:
FATHER 12. Name: Joseph Wm. Richardson
13. Birthplace: Ohio
MOTHER 14. Maiden name: Martha Kirkbride
15. Birthplace: Ohio
16. Informant: Nephew, Earle K. Richardson
Address: 608 Monroe St. Rockville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 20/48 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington, D.C.
18. Funeral director: Wm Reuben Humphrey.
Address: 7557 Wisc. Ave., Bethesda, Md.
19. 11-20 (Date rec'd by registrar) 1948 W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18, 1948 at 1:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16/nov/48 to 18/nov/1948 and that I last saw h alive on

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Pulmonary Infarct	
Due to:	
Due to:	
Other conditions: Pneumonia (Terminal hypostatic) Bilateral - not lobar Coronary Artery Disease [3/15/49 a.s.]	

(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results: As above (except brain)
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles R. Talley M.D. M. D. or other
Address: 915 - 19th St. Wash. D.C. Date signed: 18/nov/48.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct page is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52b

11611

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, Institution, or street address where death occurred: US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County: Washington

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 821 Allison St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME RODMAN, Morris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Rose Rodman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 15, 1891

8. AGE: Years: 57 Months: 5 Days: 1 If less than one day ..... hrs. ..... min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Taxi Driver

11. Industry or business

FATHER 12. Name: RODMAN, Barney

13. Birthplace: Russia

MOTHER 14. Maiden name: BROMBERG, Rebecca

15. Birthplace: Russia

16. Informant: wife: Mrs. Rose Rodman

Address: 821 Allison St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-18-48 (month) (day) (year)

Cemetery or crematory: Eversovetgard Cemetery

Location: Washington, D. C.

18. Funeral director: Danzansky & Son

Address: 3501 14th St., N.W., Wash., D.C.

19. 11-16- (Date rec'd by registrar) 19 48 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 November 19 48 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 October 19 48 to 16 Nov 19 48 and that I last saw him alive on 16 November 19 48

Immediate cause of death	DURATION
Carcinoma of the Urinary Bladder	2 yrs.
Due to Bowel Obstruction,	
Due to	
Other conditions Bowel Obstruction, Uremia, and Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. Signature: J. H. Miller Jr. Lt. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11612

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: 10000 Georgia Ave Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Prince Georges

City or town: District Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7204- Justice St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Ida C. Ross

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Willard R. Ross

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 24. 1860

8. AGE: Years: 88 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Indiana (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: David Trovinger

13. Birthplace: Unknown

MOTHER

14. Maiden name: Mary Freel

15. Birthplace: Ohio

16. Informant: Arthur Rohan

Address: 7204. Justice St. Dist. Hts. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-13-48 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md

18. Funeral director: Robert A. Mattingly.

Address: 131-11th St. S.E. Wash. D.C.

19. Nov. 10 1948 (Date rec'd by registrar) Joseph M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 1948, at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1948 to Nov. 10 1948 and that I last saw h. alive on Nov. 10 1948

	DURATION
Immediate cause of death: Acute Myocarditis	
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry Lowder M.D. M. D. or other

Address: 1603 19th N.W. Date signed 11-10-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83 b

Reg. Dist. No. 11613

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: RURAL - Redland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: & Rural - Clarksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

David Franklin RUNION

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh.	Widowed

6.(b) Name of husband or wife: Annie Rebecca Runion

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 28, 1864

8. AGE: Years 84 | Months 4 | Days 25 | If less than one day ... hrs. ... min.

9. Birthplace: Broadway Rockingham Co., Va.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER

12. Name: Rubin Runion

13. Birthplace: Va.

MOTHER

14. Maiden name: Frances Tressel

15. Birthplace: Va.

16. Informant: Mabel Dove

Address: RFD Gaithersburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/26/48 (month) (day) (year)

Cemetery or crematory: Hyattstown Cemetery

Location: Hyattstown Md.

18. Funeral director: E. C. Gartner

Address: Gaithersburg Md.

19. Nov. 24 1948 (Date rec'd by registrar) Alfreda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23 1948 at 5:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 1948 to Nov 23 1948 and that I last saw him alive on Nov 22 1948

Immediate cause of death	DURATION
Cerebral Thrombosis	5 days.
Due to: Cerebral Sclerosis	years
Due to: Senility	years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Richard A. Yates M. D. M. D. or other

Address: RFD #1 Silver Spring, Md. Date signed 11/23/48

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

59b

11614

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Sil. Spg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State: Md. County: Montgomery
City or town: Silver Spg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 10000 - Sa- Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Margaret R. Russell

3. (b) Social Security Number: None

4. Sex: F
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: W
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 17, 1865
8. AGE: Years: 83 Months: 0 Days: 2 If less than one day: hrs. min.
9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: David Gibson
13. Birthplace: New York
MOTHER 14. Maiden name: Sarah E. C. Rodier
15. Birthplace: Virginia
16. Informant: H. Haig Russell (Son)
Address: 1220 North Irvin St Arlington Va
17. (Burial, cremation or removal. Which?) removal Date thereof: 11/19/48 (month) (day) (year)
Cemetery or crematory: Washington D.C.
Location: Glenwood Cemetery Wash D.C.
18. Funeral director: J. Wm. Lee's Sons Co
Address: 1300 - 4 - St. N.E. - Wash. DC
19. Nov. 19 1948 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19, 1948, at 8 20 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20 1943, to Nov. 19 1948 and that I last saw her alive on July 9 1948

Immediate cause of death	DURATION
Arthritis	
Due to: Hypertension	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. A. A. Dunn M. D. or other
Address: Bethesda Md. Date signed: 11/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11615

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47c

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Wash. San and Hosp.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 E. Walnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Ryan, Mrs. Nannie V.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ryan, Mr. George

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 12, 1875

8. AGE: Years 73 | Months 4 | Days 25 | If less than one day hrs. min.

9. Birthplace: Shipman, Va. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER 12. Name: Campbell, Mr. Daniel

13. Birthplace: Nelson Co, Va

MOTHER 14. Maiden name: Thompson, Elizabeth

15. Birthplace: Nelson Co Va

16. Informant: Hospital Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov. 7, 1948 (month) (day) (year)

Cemetery or crematory: Ivy Lawn

Location: Alexandria Va

18. Funeral director: Glemaine & Son

Address: Alexandria Va

19. Nov. 7 1948 (Date rec'd by registrar) H. D. Quales Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7 1948 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1948 to Nov. 7 1948 and that I last saw h. alive on Nov. 6 1948

Immediate cause of death: Bronchogenic Carcinoma

Due to: with Jaundice

Due to: Arteriosclerotic Heart Disease

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Victor K. Wade M.D. M. D. or other

Address: Takoma Park Md Date signed 11-7-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108

11616

Reg. Diat. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3622 Jenifer St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

SANOWSKIS, Ernestine Grady

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Anthony Sanowskis

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 28, 1915

8. AGE: Years	Months	Days	If less than one day
33	2	26	hrs. min.

9. Birthplace: R.I. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: GRADY, Thomas dec.

13. Birthplace: England

MOTHER

14. Maiden name: McLAUGHLIN, Mary dec.

15. Birthplace: Mass.

16. Informant: husband: Anthony Sanowskis, HM1 USN

Address: 3622 Jenifer St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-27-48 (month) (day) (year)

Cemetery or crematory: Columbia Cemetery

Location: Middletown, R.I.

18. Funeral director: Reuben Humphrey Wm Reuben Humphrey

Address: 7557 Wisconsin Avenue, Bethesda, Md.

19. 11-24- 1948 Mary C. Patterson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 1948 at 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 November 1948 to 24 November 1948 and that I last saw her alive on 24 November 1948

Immediate cause of death: Lobar Pneumonia (Bilat) — DURATION: 4 d.

Due to: Rheumatic Heart Disease

Due to: Acute Congestive Failure, Cardiac Dilatation

Other conditions: Tachycardia

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. L. SPAULDING, Cdr. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11617

45b

Reg. Dist. No. 215

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (Rural) Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, institution, or street address where death occurred:
U S Naval Hospital, Bethesda, Md.
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Columbia County:
City or town: Washington D C
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Apt 769 Wardman Park Hotel
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
SCHERER, George Fulford

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Marjorie P Scherer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1 November 1905
8. AGE: Years 43 Months 0 Days 24 If less than one day: hrs. min.
9. Birthplace: Illinois (Town, county, and state)
10. Usual occupation: State Dept. Foreign Service
11. Industry or business:
FATHER 12. Name: Louis C Scherer
13. Birthplace: Minnesota (Deceased)
MOTHER 14. Maiden name: Laura Harris
15. Birthplace: Illinois (Deceased)
16. Informant: Wife: Marjorie P Scherer
Address: Apt 769 Wardman Park Hotel WDC
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 11-26-48 (month) (day) (year)
Cemetery or crematory: Cedar Hill Crematorium
Location: Suitland Maryland
18. Funeral director: Joseph Gawler
Address: 1756 Penn. Ave NW Washington DC
19. 11-27 1948 (Date rec'd by registrar)
Mary C. Patterson
Mary C. Patterson Registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 November 1948, at 4:45A
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 November 1948 to 25 November 1948 and that I last saw it alive on 25 November 1948

Immediate cause of death	DURATION
Carcinomatosis	2 mos.
Due to: Carcinoma of Tongue	18 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results: Confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. F. Harrison Jr.
W. F. HARRISON LT MC USN
M. D. or other
Address: USNH, Bethesda, Md. Date signed: 11-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11618

92d

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: GAITHERSBURG
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Pink Priscilla Schwartz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: B Dorsey Schwartz

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Sept 20th 1873

8. AGE: Years	Months	Days	If less than one day
1873 75	1	18	... hrs. ... min.

9. Birthplace: Baltimore Md,
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: "

FATHER
12. Name: John Piquett
13. Birthplace: Md,

MOTHER
14. Maiden name: Katherine Herley
15. Birthplace: Md,

16. Informant: Mr, B, D. Schwartz
Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/20/48 (month) (day) (year)

Cemetery or crematory: Bethesda Ch, Cemetery

Location: Browningville Md,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg. Md,

19. Nov. 20 1948 (Date rec'd by registrar) Alnda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 18th 1948 at 5 Am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1948 to Nov 18 1948 and that I last saw her alive on Nov 15 1948

Immediate cause of death	DURATION
Acute cardiac dilitation	1/2 hr.
Due to: Chronic Valvular heart disease	2 yrs.
Due to:	
Other conditions: arterio sclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. Borchart M.D. M. D. or other

Address: Gaithersburg Md Date signed 11-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

11619

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

947a

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Hillandale, Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, institution, or street address where death occurred:
Parkman Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Hillandale Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. Parkman Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Mr. George Herbert Shaw

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Helen Arrison Foster Shaw 6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.): April 25, 1881

8. AGE: Years	Months	Days	If less than one day
67	6	13	hrs. min.

9. Birthplace: Belmont Mass.
(Town, county, and state)

10. Usual occupation: Sr. Architectural Engineer

11. Industry or business: Dept. Agriculture, U.S. Gov't

FATHER
12. Name: Herbert Shaw
13. Birthplace: Mass.

MOTHER
14. Maiden name: Mary Louise Houghton
15. Birthplace: Littleton, Mass

16. Informant: Mrs. Helen Foster Shaw
Address: Parkman Rd, Hillandale, Silver Spring, Md.

17. Shipment & burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 10, 1948 (month) (day) (year)

Cemetery or crematory: Ivy Hill Cemetery

Location: Philadelphia, Pa.

18. Funeral director: Warner E. Pumphrey

Address: 8434 Georgia Ave., Silver Spring, Md.

19. Nov. 9 1948 Josephine M. Schaeffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7, 1948 at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7 (1:30 AM) 48 to 2:20 AM 19

and that I last saw h. alive on November 7, 1948

Immediate cause of death	DURATION
Coronary Occlusion with Acute Cardiac failure	1 hr. 50 min
Due to: Acute indigestion	1 hr. 50 min
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wallace H. Mook M.D. (M. D. or other)

Address: Takoma Park Md. Date signed 11/7/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

Dr. Frank Bronchart notified
+ approved!

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11620

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md, (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Mo.

Hospital, Institution, or street address where death occurred:
Mrs Gaithers, Rest Home,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md, County: Montg

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Eugene F, Sneeringer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 4th 1861

8. AGE: Years 87 | Months 1 | Days 18 | If less than one day hrs. min.

9. Birthplace: McSherry Pa,
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: " "

FATHER
12. Name: Samuel Sneeringer
13. Birthplace: Pa,

MOTHER
14. Maiden name: Eliza Steiger
15. Birthplace: Pa,

16. Informant: E S Tummins
Address: 202 Baltimore St, Hanover. Pa,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/26/48 (month) (day) (year)
Cemetery or crematory: St Rose Cemetery
Location: Clopper Md.

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Nov. 24 1948 Alvida L Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 1948, at 6 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1948, to Nov 23 1948, and that I last saw him alive on Nov 23 1948.

Immediate cause of death	DURATION
acute congestive heart failure	4 days
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. A. Hartley, M.D. M. D. or other

Address: Rockville, Md Date signed 11/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11621

97

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery Co Hospital
City or town: Olney Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred: Montgomery County General Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rural Cedar Grove Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Godfrey C Snyder

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary C Snyder
6.(c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.): April 15 - 1873
8. AGE: Years 75 Months 7 Days 13 If less than one day hrs. min.
9. Birthplace: Maryland (town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: George Snyder
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary S Snyder
15. Birthplace: Maryland
16. Informant: Mrs. Mary C. Snyder
Address: Germantown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 30 1948 (month) (day) (year)
Cemetery or crematory: Salem
Location: Cedar Grove Md
18. Funeral director: Roy W Barber
Address: Laytonsville Md
19. Nov 30 1948 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Oct 1948 to 28 Nov 1948 and that I last saw him alive on 27 November 1948

Immediate cause of death: arteriosclerosis { generalized / cerebral — DURATION >1 yr

Due to:

Due to:

Other conditions: anemia

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Chas Randol MD M. D. or other
Address: Damascus, Md. Date signed: 30 Nov 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11622

124b

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Montg

City or town: Gaithersburg Md,
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clarence Vinson Sparrow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 21 1881

8. AGE: Years 67 | Months 5 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Montg Co, Md,
(Town, county, and state)

10. Usual occupation: Farmer & Laborer

11. Industry or business: "

FATHER 12. Name: George W Sparrow
13. Birthplace: Md,

MOTHER 14. Maiden name: Mary E. Crown
15. Birthplace: Md,

16. Informant: Mrs J Wm Garrett
Address: Gaithersburg, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/10/48 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Md,

16. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Nov 10 1948 Alfred L Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8th 1948, at 3.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 15 1948, to Nov 8 1948 and that I last saw alive on Nov 7 1948

Immediate cause of death	DURATION
Acute Cardiac failure	6 hrs.
Due to: Cirrhosis of liver	2 mo
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. J. Broschart M.D. M. D. or other

Address: Gaithersburg Md Date signed 11-9-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11623

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2027 38th St. S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME
STAROBIN, Louis (n)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Augusta L. Starobin

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7-4-91

8. AGE: Years: 57 Months: 3 Days: 8 If less than one day: hrs. min.

9. Birthplace: Brooklyn, New York
(Town, county, and state)

10. Usual occupation: Multigrapher

11. Industry or business

FATHER
12. Name: Abraham Starobin
13. Birthplace: Russia

MOTHER
14. Maiden name: Tillie Schwartz
15. Birthplace: Russia

16. Informant: Wife: Mrs. Augusta L. Starobin
Address: 2027 38th St. S.E. Wash. D. C.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 11-5-48 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: B. Danzansky Funeral Home,
Address: 3501 14th St. N.W. Washington, D. C.

19. 11-2- 19 48 Mary C. Patterson
(Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2, November 1948, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1 November 1948 to 2 Nov. 1948 and that I last saw him alive on 2 November 1948

Immediate cause of death	DURATION
Thrombosis, Coronary Artery	24hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Queen
Wm. W. F. QUEEN, Jr., LCDR, MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83b

11624

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 22 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1625 R St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am., WWI & WWII ✓

3.(a) FULL NAME

STITT, Edward Rhodes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Helen N. Stitt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22, 1867

8. AGE: Years	Months	Days	If less than one day
81	3	21	hrs. min.

9. Birthplace: Charlotte, N.C. (Town, county, and state)

10. Usual occupation: Retired Navy

11. Industry or business

FATHER

12. Name: STITT, William dec

13. Birthplace: N.C.

MOTHER

14. Maiden name: RHODES, Mary Ann dec.

15. Birthplace: N.C.

16. Informant: Wife: Mrs. Helen Stitt

Address: 1625 R St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-16-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Joseph Gawler

Address: 1750 Pennsylvania Ave., N.W., Wash., D.C.

19. 11-13-48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 November 19 48, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 July 19 48, to 13 Nov. 19 48 and that I last saw him alive on 13 November 19 48

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to: Arteriosclerosis Generalized	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. R. Lang, F. R. LANG, Capt. MC USN, M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95b

11625

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11-23-48 - 3:20 P.M.

Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd., Bethesda, Md.

How long in hospital or institution? 11-23-48 - 3:20 P.M.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 5323-41st St., N.W. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Margaret M. Sullivan

3.(b) Social Security Number

4. Sex: F

5. Color or race: Wh.

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug., 14, 1908

8. AGE: Years: 40 Months: Days: If less than one day: hrs. min.

9. Birthplace (town, county, and state): Washington D.C.

10. Usual occupation: None

11. Industry or business:

FATHER

12. Name: John J. Sullivan

13. Birthplace: Co., Cork Ireland

MOTHER

14. Maiden name: Nora A. Driscoll

15. Birthplace: Slator Island N.Y.

16. Informant: Leo C. Sullivan

Address: 5323-41st St. N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal, which?) Date thereof: Nov. 26, 1948 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Wash. D.C.

18. Funeral director: Francis J. Collins

Address: 3821-14th St. N.W. Wash. D.C.

19. 11-24 1948 (Date rec'd by registrar) M. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/24 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/25 1948 to 11/24 1948 and that I last saw h alive on 11/24 1948

Immediate cause of death	DURATION
Congested heart failure	5 min.
Due to: Rheumatic heart disease	20 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bernard J. Hall M. D. or other

Address: 900 17th St. N.W. Wash. D.C. Date signed: 11/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11626

94a

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 Years

Hospital, Institution, or street address where death occurred:
6301 Strafford Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6301 Strafford Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Eugene Clarence Taylor

3.(b) Social Security Number: Not Known

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Elizabeth S. Taylor

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): August 6, 1882

8. AGE: Years: 66 Months: 3 Days: 11 If less than one day: hrs. min.

9. Birthplace: Albermarle Co., Va.
(Town, county, and state)

10. Usual occupation: Patent Attorney

11. Industry or business:

FATHER
12. Name: Alexander S. Taylor
13. Birthplace: Albermarle, Va.

MOTHER
14. Maiden name: Elizabeth Goodall
15. Birthplace: Madison Co., Va.

16. Informant: Mrs. Elizabeth Pflaumer
Address: Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 19, 1948 (month) (day) (year)

Cemetery or crematory: Ruckersville

Location: Ruckersville, Va.

18. Funeral director: Wm. Lawrence Humphrey
Address: 7557 Wisconsin Ave., Bethesda Md.

19. 11-18 1948 (Date rec'd by registrar) W. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 17 1948, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1940 to Nov 17 1948 and that I last saw him alive on Nov 17 1948

Immediate cause of death	DURATION
Coronary Thrombosis	15 Min
Due to: unknown	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bradley D. Hopkins MD
M. D. or other

Address: 313 W. Bradley Lane Date signed: 11/18/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

11627

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Horner's Lane-Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Horner's Lane, Rockville, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frances Thompson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Maryland J. Thompson

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): March 15th 1892

8. AGE:

Years	Months	Days	If less than one day
56	7	29	hrs. min.

9. Birthplace: Montgomery County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Jos. C. Hawkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Watkins
15. Birthplace: Maryland

16. Informant: Maurice E. Thompson (son)

Address: Same as above

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/17/48 (month) (day) (year)

Cemetery or crematory: Forest Oak

Location: Gaithersburg, Md.

18. Funeral director: Wm. Reubem Pumphrey

Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 11-16-48 19 (Date rec'd by registrar) W. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14 1948 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam case 19 to 19 and that I last saw it alive on 19

Immediate cause of death: Asphyxia by hanging

Due to: suicide

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: Found dead at home

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: 11-14-48

Where did injury occur? Rockville (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: hanging Injured at work?

23. SIGNATURE: J. J. Broschart M.D. M. D. or other

Address: Dep Med Exam Date signed: 11-14-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11628

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years - 11 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 8 years 11 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

George K. Thompson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Jessie Cornia Whitney Thompson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1860 October 29.

8. AGE:

Years	Months	Days	If less than one day
88	—	9	— hrs. — min.

9. Birthplace: Hartford Connecticut (Town, county, and state)

10. Usual occupation:

11. Industry or business: Retired Railway worker

FATHER

12. Name: Thomas Hume Thompson

13. Birthplace: Havre de Grace - Maryland

MOTHER

14. Maiden name: Iris Dewey

15. Birthplace: South Royalton - Vermont.

16. Informant: Sanitarium Records.

Address: Takoma Park. Maryland.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 8, 1948 (month) (day) (year)

Cemetery or crematory:

Location: Brooklyn, New York

18. Funeral director: W W Chambers Co

Address: 1400 Chapin St NW.

19. Nov. 8 1948 (Date rec'd by registrar) Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7 1948 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946, to Nov 7 1948 and that I last saw him alive on Nov. 7 1948

Immediate cause of death: Generalized Arteriosclerosis with Gangrene of left heel.

Due to: Senile Cataracts

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr Tor K. Meade M.D.

M. D. or other

Address: Takoma Park, Md Date signed: 11-8-48

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11629

93d

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: 131 Hesketh Street

County: Montgomery County

City or town: Chevy Chase, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 131 Hesketh Street,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MR. WILLIAM SEWALL TIBBETS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): January 12th, 1915

8. AGE: Years: 33 Months: Days: If less than one day ... hrs. ... min.

9. Birthplace: WASHINGTON, D.C.
(Town, county, and state)

10. Usual occupation: ELECTRICAL ENGINEER

11. Industry or business: ORE STEAMSHIP CORP.

FATHER
12. Name: Dr. Albert P. Tibbets
13. Birthplace: Somersworth, New Hampshire

MOTHER
14. Maiden name: Katherine Tibbets
15. Birthplace: Frederick, Maryland

16. Informant: Mrs. Albert P. Tibbets

Address: 131 Hesketh St, Chevy Chase

17. Removal (Burial, cremation, or removal. Which?) Date thereof: NOV. 6, 1948 (Month) (Day) (Year)

Cemetery or crematory: Forest Glade Cemetery

Location: Somersworth, New Hampshire

18. Funeral director: MARTIN W. HYSONG Martin W. Hysong

Address: 1300 N. STREET, N.W.--WASH. D.C.

19. Nov. 6 1948 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6 1948 at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 1947, to Nov 6 1948 and that I last saw him alive on Nov 6 1948

Immediate cause of death: Hypertension Heart Disease — DURATION: 4 yr+

Due to:

Due to: Uremia

Other conditions: Congestive Heart Failure

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C B Courville M.D.
M. D. or other

Address: 1801 - Eye St - Wash. DC Date signed: 11/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11630

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Montg. Co. Gen. Hospt. One

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)

Street No.: Howard Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: U.S.

3. (a) FULL NAME Betty Lee Tolbert

3. (b) Social Security Number none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 13, 1948

8. AGE: Years | Months | Days: 1 | If less than one day: 23 hrs. ..... min.

9. Birthplace: Olney, Maryland. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Eddie J. Tolbert Jr.

13. Birthplace: Va.

MOTHER 14. Maiden name: Martha Lofton

15. Birthplace: Va

16. Informant: Eddie J. Tolbert Jr.

Address: Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 16 1948 (month) (day) (year)

Cemetery or crematory: Potomac Church Cemetery

Location: Potomac, Maryland

18. Funeral director: Wm Reuben Humphrey

Address: Bethesda, Maryland.

19. Nov 16 1948 Gertrude B Lawler (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15 1948 at 7 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 13 1948 to Nov. 15 1948 and that I last saw he alive on Nov. 15 1948

Immediate cause of death: Prematurely (7 months) (4 lb 5 oz)

Due to:

Due to:

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION
—

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. H. Feldmann M.D. (M. D. or other)

Address: Rockville, Md. Date signed 11/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 11631 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8408 Bradmoor Dr.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John G. Underwood

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lilah Underwood

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Dec. 8th 1886

8. AGE: Years	Months	Days	If less than one day
61	10	29	hrs. min.

9. Birthplace: Adams, New York (Town, county, and state)

10. Usual occupation: Manufacture Representative

11. Industry or business

FATHER

12. Name: William Underwood

13. Birthplace: Canada

MOTHER

14. Maiden name: Catherine MacGowan

15. Birthplace: Adams, New York

16. Informant: Wife

Address: Same Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12th 1948 (month) (day) (year)

Cemetery or crematory: Mt. Hope Cemetery

Location: Sparta, Wisconsin

18. Funeral director: Wm Reuben Humphrey.

Address: 7557 Wis. Ave., Bethesda, Md.

19. 11-8 18. 48 (Date rec'd by registrar) V. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 November 19 48 at approx. 3 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 July 19 48 to 3 Nov. 19 48 and that I last saw h. alive on 3 Nov. 19 48

Immediate cause of death	DURATION
Acute myocardial Infarction	minutes
Due to: Coronary Artery Disease	2 yrs +
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert L. Brickhouse M. D.

Office: 2030 R St. N.W. Wash. M. D., or other

Residence: 4913 Bayard Blvd. Date signed: 7 Nov '48

Cincinnati, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for correction of item #5 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

93d

11632

CERTIFICATE OF DEATH

ALM No. G 113 DEC 16 1948

Reg. Dist. No. 215

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda Rural Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
U S Naval Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4733 Washington Place NE
(If rural, give LOCATION)
2.(a) If veteran, name war: World WarL

3.(a) FULL NAME
WALLACE, John (n)

3.(b) Social Security Number

4. Sex: Male
5. Color or race: ~~White~~ Negro
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 2 March 1891
8. AGE: Years: 57 Months: 8 Days: 22 If less than one day: hrs. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Caeser Wallace
13. Birthplace: Virginia dec.

MOTHER
14. Maiden name: Julia Cublin
15. Birthplace: Virginia dec

16. Informant: Stepson: Herbert Ross
Address: 4733 Washington Place NE WDC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-30-48 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Virginia

18. Funeral director: Barnes & Matthews
Address: 614 4th St. SW Washington DC

19. 11-26 1948 (Date rec'd by registrar)
Mary C. Patterson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 November 1948 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 22 November 1948 to 24 November 1948 and that I last saw him alive on 24 November 1948

Immediate cause of death	DURATION
Hypertensive Heart Disease	6 Mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. F. Queen
W.F.QUEEN CDR MC USN
M. D., or other
Address: USNH Bethesda Md Date signed: 11-26-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

11633

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days + 8 hrs

Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd.

How long in hospital or institution? 7 days + 8 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 326 Diamond Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James WALTON

3. (b) Social Security Number none.

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: single

6. (b) Name of husband or wife

6. (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 12th 1873

8. AGE: Years 75 Months 5 Days 6 If less than one day ... hrs. ... min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Shoemaker

11. Industry or business

FATHER

12. Name: William Walton

13. Birthplace: England

MOTHER

14. Maiden name: Jane Irwin

15. Birthplace: England

16. Informant: Miss Mary E. Walton

Address: 326 Diamond Ave. Gaithersburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 20, 1948 (month) (day) (year)

Cemetery or crematory: Darnestown Church Cemetery

Location: Darnestown, Maryland

18. Funeral director: Wm. Reuben Plumphrey

Address: Bethesda, Maryland

19. 11/20 1948 W. E. Jones Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 17th 1948 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 August 1948 to 17 Nov. 1948 and that I last saw him alive on 17 November 1948

	DURATION
Immediate cause of death: Acute pulmonary edema	24 hrs.
Due to: Cardio-vascular renal disease	3 years
Due to: Arteriosclerosis	6 years
Other conditions: Coronary artery disease	1 month

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John S. Fawcett M.D. (M. D. or other)

Address: P. O. Boyds, Md. Date signed: 17 Nov 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11634

MOC

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: OLNEY (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: The Montgomery County General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Norbeck (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME CLARENCE WILKERSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 9 1898

8. AGE: Years	Months	Days	If less than one day
49	11	14	hrs. min.

9. Birthplace (Town, county, and state) Bedford Co. Va.

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Albert Wilkerson

13. Birthplace VIRGINIA

MOTHER 14. Maiden name Fannie Hunter

15. Birthplace Virginia

16. Informant Hospital Records

Address Olney, Md.

17. Shipped (Burial, cremation, or removal. Which?) Date thereof Nov. 26, 1948 (month) (day) (year)

Cemetery or crematory

Location Bedford, Va.

18. Funeral director Robert L. Snowden

Address 246 N. Washington St. Rockville Md

19. Nov 23 1948 (Date rec'd by registrar) Gertrude B Fowler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1948 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam case 19 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Shock	
Due to: Extensive thoracic hemorrhages	3 days
Cerebral edema	
Due to: Accidental	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 11-20-48

Where did injury occur? Mr. Norbeck (City or town) Montg. (County) Md (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury struck by auto Injured at work? no

23. SIGNATURE Frank J. Broschart M.D. Dep. Med. Exam M. D. or other

Address Gaithersburg Md Date signed 11-23-48

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

123

11635

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred: Montgomery Gen Hosp Olney Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Monroe St
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME John J. P. Hirz

3.(b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Clara Hirz
6.(c) If alive, give age: 71 years
7. Birth date of deceased (mo., day, yr.): 9/16/1875

8. AGE: Years 73 | Months 1 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: None. Retired Farmer
11. Industry or business

FATHER
12. Name: John J. Hirz
13. Birthplace: Va, Louden County

MOTHER
14. Maiden name: Mary E. Mock
15. Birthplace: Va, Louden County

16. Informant: Paul Hirz
Address: Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 15, 1948 (month) (day) (year)
Cemetery or crematory: Rockville Union
Location: Rockville Md

18. Funeral director: Wm. Reuben Humphrey
Address: Bethesda, Md.

19. 11-12 1948 Gertrude B Fowler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12/ 1948 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/2/ 1948 to 11/12/ 1948 and that I last saw him alive on 11/12/ 48 1948

Immediate cause of death: Terminal Pneumonia — Duration: 5
Due to: Resection of Sigmoid Neoplasm — 7 yrs.
Due to: Leakening Arteriosclerosis — 5 days
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Hepatic nodules
Date of op. 11/4/48
Autopsy results: Abdomen only. Fm Bethesda
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. Bird M. D. or other.
Address: Barnesville, Md. Date signed 11/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 11636 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 103-Summitt Av.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William C. Yokum

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel V. Yokum

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 4-1903

8. AGE:

Years	Months	Days	If less than one day
45	9	18	hrs. min.

9. Birthplace: Washington-D.C.

(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business

FATHER

12. Name: William T. Yokum

13. Birthplace: Georgia

MOTHER

14. Maiden name: Mae Lorraine Moncrief

15. Birthplace: Ala.

16. Informant: Otis M. Yokum

Address: 4520-36th-St-N.W. Wash-D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov-24-48 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Pr. Ge. Co. Md.

18. Funeral director: Deal Funeral Home

Address: 4812-Georgia Ave-N.W. D.C.

19. 11-23 19 48 (Date rec'd by registrar) W E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 November 19 48 at 3:35 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 19 47 to 22 Nov 19 48 and that I last saw him alive on 22 Nov 19 48

Immediate cause of death	DURATION
Coronary Thrombosis	one hour
Due to: Coronary Sclerosis	5 yrs.
Due to:	
Other conditions: Had coronary thrombosis in 1945 (Proved) (Include pregnancy within 3 months of death)	

Major findings of operation: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Stewart Blair M.D. M. D. or other

Address: 3921 Oregon St. N.W. Date signed: 12 Nov 48

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

552

11637

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 19 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3819 T St., N.W.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3.(a) FULL NAME
ZIMMER, Clarence William

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Violet Zimmer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): February 21, 1891

8. AGE: Years	Months	Days	If less than one day
57	9	0	hrs. min.

9. Birthplace: Wisconsin (Town, county, and state)
10. Usual occupation: U.S. Government
11. Industry or business: Internal Revenue

FATHER
12. Name: ZIMMER, Daniel dec.
13. Birthplace: Wis.

MOTHER
14. Maiden name: CULVER, Addie dec.
15. Birthplace: Wis.

16. Informant: wife: Mrs. Violet Zimmer
Address: 3819 T St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11-23-48 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: S. H. HINES
Address: 2901 14th St., N. W., Wash., D.C.

19. 11-21 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 November 19 48, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 October 19 48 to 21 November 19 48 and that I last saw him alive on 21 November 19 48

Immediate cause of death	DURATION
Peritonitis General	10 days
Due to: Intestinal Obstruction	One mos
Due to: Carcinoma Recurrent Sigmoid Colon	14 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinomatosis Abdominal Date of op. 10-28-48
Autopsy results: confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. M. Hanner
J. M. HANNER, Cdr. MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed 11-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 C

11638

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Enroute to Hosp.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty.

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 703 Gail Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carl Zirkle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife: Mildred Melvin —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb. 1. 1918

8. AGE: Years	Months	Days	If less than one day
30	9	25	hrs. min.

9. Birthplace: Rockingham County, Va.

(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: Lumber Co.

FATHER

12. Name: A. L. Zirkle

13. Birthplace: Va.

MOTHER

14. Maiden name: Elizabeth Bare

15. Birthplace: Va.

16. Informant: H. T. English

Address: 703 Gail Ave. Rockville Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11-26-48 (month) (day) (year)

Cemetery or crematory

Location: Broadway, Va.

18. Funeral director: G. G. Rhodes

Address: Broadway Virginia

19. Nov. 26 1948 Ursula G. Cooke Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25 1948 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. med Exam 19 to Date 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture of 3rd cervical	50 min.
Due to: Vertebra	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 11-25-48

Where did injury occur? Germantown (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury: auto accident Injured at work? no

23. SIGNATURE: Frank J. Bronhard M.D. M. D. or other

Address: Germantown Md Date signed 11-25-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

11639

Reg. Dist. No. 316

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1968 Capital View Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Laura Zirkle

3.(b) Social Security Number

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: Otis

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 28, 1883

8. AGE: Years: 64 Months: 11 Days: 4 If less than one day hrs. min.

9. Birthplace: Forestville Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Charles Shutters

13. Birthplace: Forestville, Va.

MOTHER 14. Maiden name: Ophelia Peuce

15. Birthplace: Forestville, Va.

16. Informant: Mrs. Thelma Ellerman (daughter)

Address: East-West Highway, Silver Sp

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1948 (month) (day) (year)

Cemetery ~~or crematory~~: Forestville Cemetery

Location: Forestville, Virginia

18. Funeral director: Dallinger & Son

Address: Mountlake, Md.

19. 11/2 19 48 Jm. E. Jones (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1, 1948 at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Oct. 1948, to Nov. 1 1948 and that I last saw he alive on Nov. 1 1948

		DURATION
Immediate cause of death	Myocardial Failure	1 day
Due to	Myocardial Infarct	14 days
Due to	Coronary thrombosis	14 days
Other conditions	Diabetes Mellitus	6 months

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Roger Lantz M.D. M. D. or other

Address: 3130 Wis. Ave NW Date signed 11/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M